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Reader's Guide

Greetings to all of our readers in this the first number of Volume 43! The months roll past so quickly that it scarcely seems possible it is twelve of them since we opened the last volume. The entire staff at your *Journal* office unite in hoping that 1947 will be a splendid year for each one of you. We hope that as each day unfolds it will reveal new joys, new successes and, above all else, a step nearer to the peace and security for which each of us yearns.

It is customary for the president of the Canadian Nurses' Association to write the lead article for the New Year's issue of the *Journal*. Each of our presidents has been a very busy woman in her own position with the demands and responsibilities of her work in our national association superimposed. When they take time out to write for us they always have a message that is well worth reading. **Rae Chittick** has given us a challenge which we must not shirk if we would be true to our calling. Our responsibility as nurses goes beyond caring for the physical needs of our patients. Do not miss reading this editorial.

Maternal and neonatal mortality are matters of serious concern. Many of these deaths seemed without a known cause. Today, our research scientists have demonstrated that some of these mothers and babies may be lost because of the mixing of antagonistic blood elements — the Rh factors. **R. L. Denton, B.Sc., M.D.C.M.,** who has described how this comes about, is Director of the Department of Hematology at Children's Memorial Hospital, Montreal, after taking special courses in this work at Harvard. Dr. Denton is also Director of the Blood Banks at the D.V.A. hospitals in the Montreal area.

Though their undergraduate training gives them an insight into the rate at which hospital supplies are used, and though some of them have had post-graduate courses in hospital administration, every nurse who finds herself confronted with the responsibility of doing the purchasing for her hospital has qualms as to whether or not she is going about the job in the right way. **Hilda Bartsch,** from her years of experience as superintendent of the Victoria Public Hospital, Fredericton, N.B., gives sound advice which will help the novice over many rough spots.

One of the most active lines of medical research today is the attempt to find the cause of cancer. Coupled with this is a pressing need to make all of our people aware of the facilities that are available for controlling and curing this disease. One of the most useful avenues of education is the nursing profession yet few nurses know all of the facts. The Canadian Cancer Society has undertaken to assist us with the task of supplying this information through a series of regular releases. **Alice K. Smith, R.N.,** the author of our first article, is associated with the Manitoba Cancer Relief and Research Institute. This series will appear regularly throughout this year.

A great many nurses return to their own hospitals to work after graduation but there are some who yearn for distant fields. Whether they engage in private duty or in general staff work, they feel somewhat at a loss as they enter a strange hospital. "Where do we go from here?" is a typical reaction. **Mrs. Mildred Koch,** of Winnipeg, has given us some suggestions, which, if adopted by our hospitals, would smooth out many of these problems.

Volunteers have been used in hospitals and in public health agencies for many years now. **Katherine Barr** has assessed the value of the contribution that they have made to the work of an official agency. Miss Barr is with the nursing division of the Winnipeg Health Department.

Preview

We often speak, more or less facetiously, about having a "brain wave" indicating that we are planning some new or varied pattern of behavior. Next month we are bringing you an authentic account of the technique for measuring the electrical impulses in the brain by means of electroencephalography. **Dr. Herbert H. Jasper** and **Margaret Goldie Jasper** have explained it simply enough that we can all understand its value for certain forms of diagnosis.

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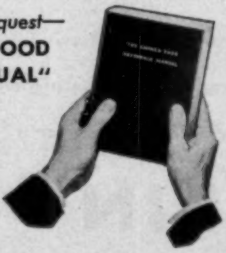

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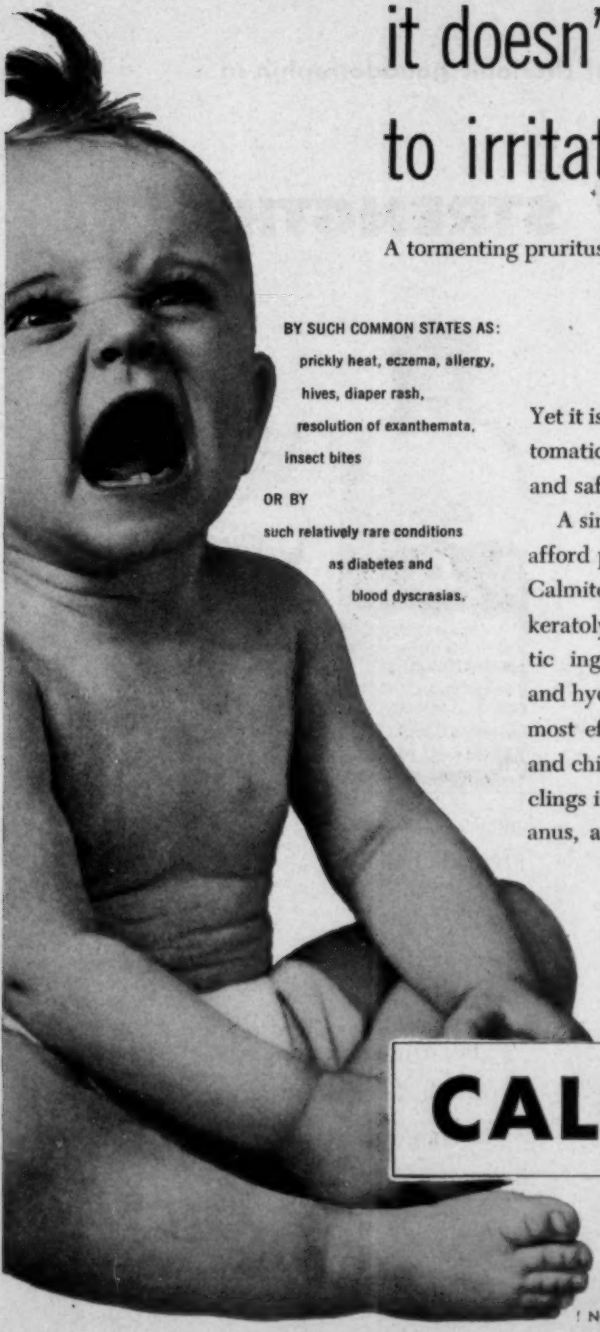

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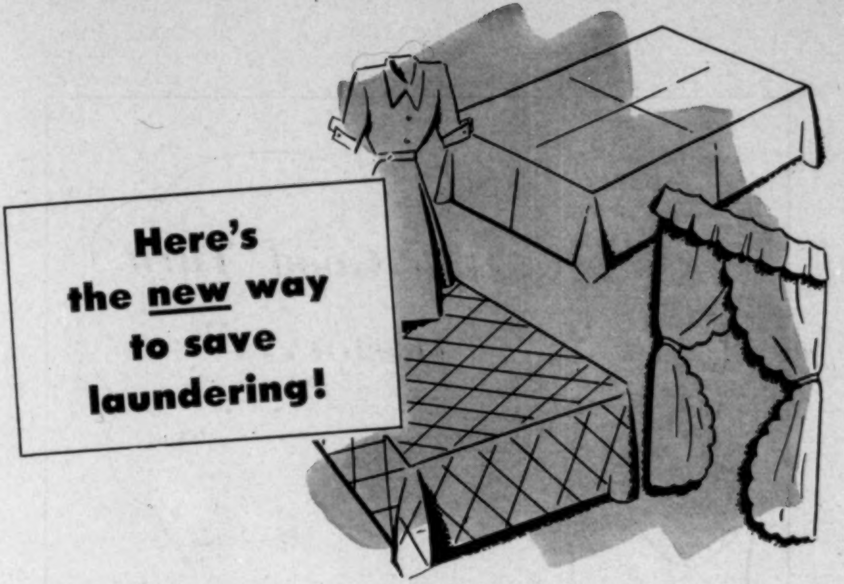

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PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE NUMBER ONE

MONTREAL, JANUARY, 1947

Our Threatened Values

ONE CANNOT BEGIN a New Year without looking back at the old, for it is by consideration of the past that we build our plans for the future. Reflection on the tragedies of the last few years brings one to the conclusion that there are two kinds of damage in war: the visible and the invisible. The visible damage in the war just concluded was appalling—a tremendous loss of life and property. But the invisible damage, perhaps, was worse—the loss of human values which constitute the foundation of our whole society.

We, as members of the nursing profession, must concern ourselves with two of these values—firstly, the dignity of the individual, and, secondly, his responsibility. Both of these values have emerged from the war perceptibly weakened, and many thoughtful people are asking whether they can even survive.

The idea of individual dignity implies respect for one's own personality and that of others. Victor Gollancz says in his recent book, "Our Threatened Values," that respect for the human personality is the greatest value of all. This respect does not necessarily mean admiration or approval for every person—our feelings are often just the opposite—but it does mean the recognition of every person's basic rights as a human being, an individual.

Mr. Gollancz points out: "When we say that we respect personality, we mean that we recognize in every human being something special, particular, concrete, unique—something in its own right."

During the war, we lost sight of this. We had not time to think of the individual and his right: we thought of people in groups and masses. Those who belonged to one particular group were human, and had rights; those who belonged to another group were inhuman, and had none. This attitude is inevitable in war, but unless it is overcome in peace it will undermine the whole foundation of civilization.

As for the sense of individual responsibility, you have marked, with your own eyes, its great deterioration during the last few years. People have become accustomed to laying the blame somewhere else, placing the responsibility somewhere else, looking for help and guidance somewhere else. There is a widespread tendency not to set one's own standards, but to follow the standards set by others: not to ask "What must I do?" but to ask "What are the rest doing?"

The nursing profession has not escaped this loss of individual responsibility. The idea of personal service and sacrifice, of duty freely accepted and rigorously sustained, has lost some of its strength among us. We must, at all costs, restore it.

Here our task lies—in the coming year and in the years to follow, we must do what we can to restore the values of civilized society. We must accept each man (and woman) as a distinct personality and we must respect his uniqueness for he has a citadel which is sacred and is possessed of inviolable human rights. We must endeavor to restore responsibility to the individual, for without individual responsibility society lacks stability and integrity. We must win back, as best we can, these important values without which any civilization, however highly organized, however "progressive," is only a mockery.

RAE CHITTICK
President
Canadian Nurses' Association

Stop Press!

Epoch-Making News

HISTORY IS REPEATING ITSELF in the matter of relationships between the Canadian Red Cross Society and Canadian nursing; it is a story of happy co-operation between two groups who have common interests.

The beginning was made at the end of the first World War when the Canadian Red Cross, through its provincial divisions, enabled the nursing profession to make progress in the field of nursing education by the establishment of formal post-graduate courses in a number of our universities. It was financial support from the Red Cross over a trial period that made this possible. Now, at the end of this second war, the Red Cross is putting its faith in us again, and again it is promising support for developments in nursing education.

The Canadian Nurses' Association has been able to name the project upon which it wishes to concentrate, and this time the intention is to strengthen the basic professional course by establishing a demonstration school which is to have financial independence, though still a "hospital school" in general character. As the student is to be freed from economic dependence upon the hospital coffers, all of her time can be used to her own practical advantage; thus it is hoped that the length of the basic course can be made appreciably shorter. The graduate of this demonstration school is to have full registration status, and thus to be made eligible for post-graduate courses designed for graduates of approved nursing schools. The Red Cross has promised financial support for a four-year demonstration period. This evidence of faith in our professional group provides a challenge which the C.N.A. hopes to meet as worthily as did our sisters of 1920.

The Practical Importance of the Rh Factor

R. L. Denton, M.D.

The history of the development of knowledge concerning blood groups and transfusions provides one of the interesting stories of medical research and an example of the determination of a single individual, Professor Karl Landsteiner. Previous to 1900, blood transfusion was an extremely risky procedure, in spite of many attempts over a period of more than a hundred years prior to this date. At this time, Dr. Landsteiner demonstrated that the blood of human beings could be divided into four main groups, which he called A, B, AB and O, and that transfusion of blood of the same group to a recipient was a safe procedure, whereas the transfusion of a different group was usually fatal. His efforts, however, did not cease at this point and a few years later he demonstrated two additional characteristics of human blood, which he called M and N, providing thereby three new types, M, N and MN. Still later, he was instrumental in discovering an additional type, which he called P. At this time Dr. Landsteiner was so certain that still undiscovered group characteristics existed that he forecast that it might be possible at some time to recognize individuals by their blood groups and types with as much accuracy as is possible by fingerprints.

In spite of advancing years, he continued his search for blood characteristics and, in conjunction with Dr. Alexander Wiener in 1940, he demonstrated another blood type, which he called the Rh type. Since then it has been found that this Rh type is present in approximately 87 per cent of white people, these individuals being called Rh positive. The 13 per cent of white people who do not have this characteristic are called Rh negative. However, in other races, the proportion is somewhat different. The Negro race is 90 per cent positive and 10 per cent negative; Oriental races are almost without exception Rh positive.

THE NATURE OF THE RH TYPE

The Rh factor, as it is called, is attached to the red blood cells and is undoubtedly present in the individual tissue cells as well. There is some evidence to show that it is present in soluble form in plasma and the various secretions of the Rh positive individual.

The Rh characteristic is acquired by an individual by direct inheritance from his parents. We now know that every individual may have two Rh genes, one of which is transmitted to his or her child. Each of us receives one Rh characteristic from our mother and one Rh characteristic from our father. There are, therefore, three possible combinations of individuals:

1. Those who are completely Rh positive (homozygous).
2. Those who are a combination of one Rh positive gene and one Rh negative gene (heterozygous).
3. Those who are completely Rh negative.

The practical importance of the Rh factor lies in its ability to stimulate the formation of Anti-Rh antibodies when introduced into the body of a person who does not have this Rh characteristic. This antibody does not occur naturally in any Rh negative person but, following the introduction of Rh positive material, the antibody is formed and that Rh negative individual is said to be "sensitized." There are three possible routes by which the Rh factor may enter an Rh negative person and thereby set up a state of sensitization. These are:

1. *By pregnancy:* An Rh negative mother may have, in utero, an Rh positive fetus, whose Rh type was inherited from the father who is Rh positive. Small amounts of blood or

tissue cells from the fetus enter the maternal circulation through the placenta during pregnancy, or as a result of torn blood vessels at labor. Anti-Rh antibodies are then stimulated in the mother and, as a result, she is "sensitized." As a rule, the fetus which causes the sensitization is not affected by the Anti-Rh antibodies of the mother, probably because sensitization does not take place until very late in that pregnancy or may not even occur until several days after the time of delivery. Subsequent pregnancies, however, in which the fetus is Rh positive, are subject to an ever-rising degree of sensitization in this mother. In the later stages of pregnancy, the Anti-Rh antibodies of the mother begin to return through the placenta back to the very infant which stimulated their production. The antibody, being specific for the Rh positive blood and tissue cells of the baby, causes damage to these tissues and the result is a severe degree of anemia, due to destruction of red blood cells and, in addition, damage to liver, spleen, and other organs. This condition is called erythroblastosis, or hemolytic disease of the newborn. The severity of damage to the infant is usually mild in the first child to be affected but, with subsequent Rh positive pregnancies, the damage becomes increasingly more severe and finally reaches the stage of causing death of the infant shortly after birth, or miscarriage late in pregnancy. Fortunately, however, sensitization of the Rh negative mother by an Rh positive fetus does not occur in every case where such incompatibility exists. For some reason or other, only 1 in 20 such mothers becomes sensitized and has an affected infant. The remaining 19 do not become sensitized and may have perfectly normal children, even though they be Rh positive.

2. *By transfusion:* In transfusion therapy, a large number of blood cells are introduced into a recipient. If that recipient is Rh negative there is an 87-13 chance that he or she will receive Rh positive blood, unless special tests are done beforehand to ensure that the recipient receives his or her own Rh type of blood. If such precautions are not taken and Rh positive blood is transfused into an Rh negative individual, a state of sensitization to the Rh factor, with the production of Anti-Rh antibodies, will occur in more than 40 per cent of such individuals. The transfusion responsible for initiation of sensitization gives no demonstrable reaction, except for the production of Anti-Rh antibodies which can be recognized by special tests. Subsequent Rh positive transfusions, however, may introduce another large amount of Rh positive blood into an environment where specific Anti-Rh antibodies are lying in wait; the antibodies attack and destroy the blood cells being infused and the result is severe, very often fatal, hemolytic transfusion reaction. It is possible, of course, for the combination of pregnancy and transfusion modes of sensitization to occur in rapid sequence, as, for example, an Rh negative mother, who has been sensitized by pregnancy, may have a postpartum transfusion and die as a result of destruction of Rh positive transfused blood by the antibodies she developed as a result of pregnancy. Similarly, an Rh negative mother who has been sensitized, even in early childhood by a transfusion of Rh positive blood, stands a good chance of losing all of her children, even the first, since her chances of marrying an Rh positive man and having Rh positive pregnancies are 7 to 1.

3. The third means by which Rh sensitization can occur is, fortunately, infrequent, that is, *via the intramuscular injection* of Rh positive blood into an Rh negative person. This procedure, once the common therapeutic technique for the treatment of hemorrhagic disease of the newborn, is, fortunately, almost nonexistent since the advent of vitamin K. There are cases on record, however, in which female infants have been sensitized in this way and remain sensitized until their child-bearing years, at which time they lost their first and subsequent Rh positive offspring.

It is of the utmost importance that we remain aware of the catastrophic effects of Rh sensitization and do everything in our power to avoid their recurrence. Methods of prevention are restricted at the present time to blood transfusion therapy. It is essential that every recipient of transfusion, but especially girls and women before or during child-bearing years, should be typed for the Rh characteristic and when Rh negative that they receive only Rh negative blood. This, of course, applies to all recipients of transfusion since one can never be certain today that further transfusions will not be necessary at some later date, perhaps with the patient in an unconscious state where he or she is not able to inform the attending doctor that Rh sensitization may have occurred in the past. There is, unfortunately, no prevention for Rh sensitization due to pregnancy. It has been proposed by one authority that marriage of an Rh negative woman to an Rh positive man be discouraged, but one may easily argue that there are other incompatibilities in the state of marriage of greater potential danger than a 1 in 20 risk of Rh sensitization. It is essential, however, to type and recognize Rh negative pregnant women, in order that one may be prepared for the birth of an erythroblastotic infant, and have all the necessary therapeutic equipment available in order to give the infant the best chance of survival. The early delivery of an Rh negative woman, known to have a rising Rh antibody level, has succeeded in many cases in saving an anemic baby, where previous full-term children had not survived.

The thing of greatest importance, to repeat, is to avoid sensitizing Rh negative individuals to the Rh factor, by taking every possible precaution to ensure that donors and recipients of transfusion have the benefit of recognition of their Rh type.

The Superintendent Does the Buying

HILDA M. BARTSCH

In most small hospitals the nurse superintendent is responsible for the buying of supplies in addition to her numerous other duties. The variety of articles needed for departments from the operating-room to the boiler-room is legion and can be considered under the following headings: medical and surgical supplies, drugs, anesthetics housekeeping equipment, linen, stationery, maintenance supplies, and provisions. No attempt to discuss provisions is going to be made in this article. To nurses, who become hospital superintendents, buying in large quantities is a new experience and presents a problem.

If the problem is to be solved certain tools are needed. These include:

1. A system of listing the amounts of supplies purchased so that quantities and prices can be seen at a glance. There are a number of types of index systems and perpetual inventory forms which may be obtained from the stationery supply houses. However, the simplest method is to use ordinary 5″ x 3″ filing cards, arranged alphabetically.
2. A library of catalogues of surgical instruments, equipment of all kinds, drugs, furnishings, cleaning supplies, and of the various other articles, is needed.
3. A list of reputable dealers.
4. A letter-size filing drawer for advertising matter, which seems to be worth keeping, or which may be needed for future reference.
5. A file for prices and quotations, which will show the name of the firm, price, and

quantity to which price applies and the date. Here again the 5" x 3" filing card is convenient.

6. Order forms printed with the name of the hospital, space for a purchase order number and shipping instructions, as well as space for the name of the firm to which the order is being sent and their address. The original is sent to this firm and a copy of the order retained and filed. All goods purchased should be covered by official hospital orders and if ordered by telephone a confirmation should be sent. It is good policy to have it understood that goods will not be accepted unless so ordered. The order forms should be numbered and filed according to number.

The amount of stock which should be carried is influenced by several factors, such as the amount needed to cover somewhat more than the average needs during time it takes to procure new stock. This, in turn, will depend on the rate of consumption, distance from supply houses, and speed of freight or express deliveries. In the case of freight deliveries, there have been times during the last few years when it has taken up to six weeks to receive material from a distance which is less than a twenty-four hour trip by passenger train. If there is more than one railway line, one may be more direct than the other. If so, it is wise to designate the route by which goods are to be shipped when placing orders. In larger centres, where supply houses are located, daily deliveries can usually be obtained, but this does not apply to small hospitals at a distance from such centres.

The amount of money available may govern quantities of goods which can be bought at one time. Theoretically, a budget should be made up and the amount to be spent on the various types of supplies estimated. Judging from discussions and articles on the necessity of uniform methods of accounting, it is doubtful if many hospitals have the information needed for this purpose in a readily available form. If the hospital has an overdraft or has to pay interest on bonds, it is not wise to buy large quantities of goods to obtain a better price, when this saving will be wiped out by interest charges.

Prices on all materials desired should be obtained from competitive firms. During the past few years the various controls have stabilized prices, so that prices on equal quantities of the same quality goods showed little variation. When these controls are removed, it will become necessary to check carefully to see that the best possible prices are obtained. Already one can see signs of dealers attempting to book orders for delivery considerably into the future. The following experience will illustrate this point: The representative of a soap company called on the long distance telephone and asked if we would place an order with him for delivery some months hence. As it happened the name of both the agent and his firm were unknown to me and I said we did not place verbal orders. The price offered was very slightly below current prices from the well-known firms, but this was laundry soap which he was selling, and a change in the type of soap would upset our washing formula and, therefore, would not be worth the slight saving. This story also shows how many things have to be taken into consideration when buying hospital supplies.

On certain supplies, such as gauze, contracts may be made and deliveries taken over an extended period. In this way it is often possible to secure a better price, than on the amount which would have to be delivered in one month.

At the time of writing, the lines which are still in short supply seem to be paper, textiles, dishes, and soaps. Quinine, as everyone knows, has been off the market since early in the war. Surgical instruments of good craftsmanship had not been obtainable since early in the war years, until fairly recently when some instruments of European manufacture again were available for Canadian hospitals. This will give hospitals the opportunity to increase their stocks of instruments or to make much needed replacements.

The question of buying from one dealer, or of spreading purchases, is one on which opinions vary. If there are competitive dealers who give the hospitals the same service it is a good idea to divide the orders. However, in some lines the question of quantity would enter the picture, and orders should not be divided between two firms if that is going to cost the hospital more for the goods. Some hospitals buy from one firm one month and from another the following month. If merchandise procured from a supplier is durable and gives satisfaction it may be wise to continue buying from that firm. The more that the purchases are spread among different firms, the more accounts there will be to increase the work of bookkeeping.

Whether or not to see salesmen will depend on a number of factors. Sometimes it is worthwhile, when information obtained will save considerable correspondence. While it is a help to try to have fixed hours for salesmen to call, this is not always possible outside of the larger centres, as train and bus schedules may make it impossible for the salesmen to call at the time fixed. If the hospital has no use for the goods a particular company is selling, then it would seem a waste of time to see their representative a second time. They should not be permitted to visit wards and departments.

There is a mass of technical information about all of the types of supplies needed in a hospital and some knowledge must be acquired. However, to learn all about such a variety of articles would take the superintendent more than twenty-four hours a day; so if she will use commonsense in regard to most of them and apply the knowledge learned in the practice of nursing regarding many articles in everyday use, she will find she is able to buy wisely. Standardization of equipment will help to cut down the variety of articles to be bought.

Articles may be found in the various hospital magazines covering various aspects of buying. An article in the *Modern Hospital* for January, 1946, entitled "Purchasing Remains Impersonal" which covers very fully the question of gifts, donations, and free samples, is well worth reading. *The Canadian Hospital* for February, 1946, contains an up-to-date Buyers' Directory, which lists most of the Canadian dealers in hospital supplies. "The Purchasing File," formerly "The Hospital Year Book," issued by the Modern Hospital Publishing Company, contains a much more detailed list of hospital suppliers, but these are practically all American firms. Buying American products means that the cost of the goods will be increased by the amount of American exchange that has to be paid. The question of duty should also be considered, when the final cost of American supplies is computed.

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Preview

Last month we featured Tuberculosis as our main theme. Next month we propose to give special prominence to various aspects of psychiatry and psychiatric nursing. **Dr. Ewen Cameron, Mildred Nelson,** and **Ella G. Smith** will be our contributors.

The Nurse and Cancer Control

ALICE K. SMITH

THE NURSE'S OPPORTUNITY for service has never been greater in any field of endeavor than it is today in the field of cancer control. The challenge which this problem presents has never been surpassed. Soon after the student enters the school of nursing, she is confronted with this challenge and from then on the possibilities for service multiply.

Our responsibility really begins before we enter the school of nursing, the responsibility which is that of every adult to know the essential facts concerning the disease. Through expansion of the work just being commenced in high schools, it will not be long before nurses entering schools of nursing will have a much truer conception of the nature of cancer itself and the cancer problem than many of us had when we graduated. Up to the moment, however, not every student nurse has received previous instruction in this subject. The result is that her attitude may be distorted by erroneous beliefs still held by many people; she may be unduly pessimistic about the whole problem. Extreme pessimism is commonly the attitude of the uninformed, and this is not surprising since a death from cancer in any community becomes common knowledge, while very few people hear about those friends and acquaintances who have been treated successfully.

Only through a thorough understanding of today's knowledge concerning the disease can a nurse make her most effective contribution. Her attitude toward the whole problem must be carefully molded by factual information early in her nursing experience. This is important because a high percentage of our hospitalized cancer patients receive their care almost exclusively from student nurses. In order to be of maximum help to the patient she must be equipped with more than a knowledge of nursing procedures.

On the surface, it would appear that the nursing care required by a cancer patient is simply *good general nursing care*, plus alertness for changes in the condition of the patient, and ability to carry out with skill orders as prescribed by the physician in charge. Actually, the responsibility of the nurse caring for a cancer patient is much greater than this. Due to the fact that cancer can be, and is, if allowed to advance before recognized, an alarming disease both to the patient and to his family, the part which the nurse is privileged to play extends far beyond the skill with which she is able to carry out procedures. The care of the cancer patient provides one of the greatest opportunities to practise nursing as an art. The psychological aspect, the ability to lend fortitude which will relieve the mental suffering of the patient, is so important. To realize the truth of this one has but to imagine one's self on the place of the patient or his family. Even with the knowledge that the cancer patient definitely can be treated successfully if the disease is found early enough to be completely eradicated, the diagnosis of cancer of most sites remains a very sobering experience.

It is true, patients are not always told they have cancer. While some doctors make a practice of never telling the patient that he has cancer, others almost always tell the patient. Most doctors consider each patient individually in this regard, telling those they judge should know and withholding the knowledge from others. Some member of the family is almost always informed. It is generally acknowledged that the best co-operation is received from patients who are informed concerning the true nature of their condition. Whether or not the patient knows that he has cancer soon after a diagnosis is made, nine out of ten who are treated in the later stages of the disease will know eventually. When, through her close association with the patient, the nurse learns that the patient does know the true nature of his condition despite the fact that he has not been told by his doctor, she should see that the doctor is informed of this fact. Confidence in his doctor, and all those in whose hands he finds himself, is essential to the well-being of the patient. Confidence is not strengthened by deceit, even when the cause may appear to have been in the best interests of the person being deceived. In regard to those who are treated early and successfully it would seem that most of them, at least, should be told the truth at some time. Such knowledge would do much to dispel the deeply rooted traditional belief that cancer is always a hopeless disease.

A sincere and unlagging interest in the welfare of the patient should be shown at all times. Whether or not he has been treated early, kindly optimism and cheerfulness used with the best possible judgment should prevail. This will assist the patient who is going to get well in adopting the correct attitude, and certainly will do much to alleviate the mental distress of the terminal patient. This, in many cases, is his greatest need. The words of Dr. Hyman Goldstein, in his article "Nursing the Aged," states most aptly:

> Your very thoughts will unconsciously mold your actions. As a result your patient will sense your thoughts instinctively, and this may work for or against you. Your gentle touch as you braid the hair of the kindly diabetic in Room 36 will tell her volumes. But awkward hesitant movements will reveal the conflict within you and will tell your cancerous patient that you dislike sponging him. To your patient this is but further evidence to bolster his already well-formed belief that he is not wanted.

Regardless of whether or not the patient knows the true nature of his condition, the principles involved in the nursing care remain the same.

While experience in this field begins in the hospital with the actual bedside care of the cancer patient, there are many avenues within the whole plan for cancer control, through which the nurse can render valuable service. In order to have a clear picture of how and where the nurse fits into an overall cancer program, let us review briefly the problem which the disease presents.

Cancer is, of course, a fundamental disease of the cellular structure of the body. There are as many different characteristics of the disease as there are different cell characteristics, and there are as many cell characteristics as there are organs. One has to be prepared to have different ideas about the disease in different parts of the body, ideas as to its incidence and of the chance of recovery of the patient, as to the methods of treatment, and so on.

Today the only hope of treating a cancer patient successfully lies in the complete eradication of all cancerous cells. This is possible when the disease is found early because it is localized. Once metastasis has begun, however, the chances of cure drop rapidly because the cells frequently migrate to obscure areas where they escape removal by surgery or destruction by radiation.

The fact that the disease rarely causes pain or discomfort at its onset, and that the first symptoms, when they do appear, are exceedingly mild deviations from the normal, is largely responsible for the fact that cancer often reaches a moderately or even far advanced stage before it is recognized. If the disease were painful at its onset the problem of early diagnosis would be very greatly reduced.

The accompanying table deals with the incidence of cancer according to site. It also gives the chance of cure that may be expected as of today, and the chance of cure that may be anticipated in what we hope will be the not too far distant future as the plans for cancer control are extended throughout this Dominion.

All in all, it will be seen that there is a very real expectation of hope for every second cancer patient, and the picture looks very grim indeed for the other 50 per cent.

CANCER CASES			Actual Recovery Percentage According		Estimated Recovery Percentage Under Ideal Conditions According	
Site	Number of cases	Percentage of total cancer cases	to site	to total cancer cases	to site	to total cancer cases
Buccal	71	5.6	76	4.2	95	5.3
Digestive	509	40.3	17	6.8	25	10.1
Respiratory	81	6.4	15	1.0	20	1.3
Uterus, all sites aver.	80	6.3	40	2.5	90	5.65
Other female genital	38	3.0	26	1.0	50	1.5
Breast	158	12.5	45	5.5	75	9.4
Male genital	66	5.2	47	2.4	75	3.9
Urinary	83	6.6	37	2.4	50	3.3
Skin	49	3.9	71	2.8	99	3.9
Other Sites	125	10.0	32	3.2	50	5.0
TOTAL	1260			31.8		49.3
			Present average recovery rate		Estimated best recovery rate	

Considering the grim side of the picture first, we realize this very unhappy situation is due to the fact that the fundamental scientific knowledge about the cancer processes is nothing like the knowledge that we have about many other diseases, particularly the infectious diseases. At present, the machinery that goes wrong to upset the normal cells of the body organs and cause them to be malignant is not understood, nor at the moment is there any clear picture as to how one should go about causing the cancer cells to return to normal. Until such knowledge is available, it is obvious that no method aimed at curing the cancer itself can exist. There is, then, a vital need for extensive scientific investigation of the cancer problem. This, of course, will only be forthcoming when the public is so aware of the necessity of carrying out this class of work that it will be prepared either to support it directly or back up governments in setting aside money for this purpose. The nurse has many opportunities to interpret this need.

To turn attention now to the brighter side of the picture, to the 50 per cent that can be saved, it will be appreciated at the outset that the methods of treatment used are not aimed at curing the cancer itself but rather at eradicating it from the body so that the patient may be free from the disease.

The main emphasis in cancer therapy is upon surgery. X-ray and radium also have a place in the treatment of cancer patients but this place is largely subsidiary to surgery. Radium and x-ray tend to destroy every living thing with which they come in contact and their destructive action increases with the activity of the living unit which they strike. Their value in the treatment of cancer patients lies in the fact that cancer cells are more actively growing than their healthy neighbors, and so radiations may be successful in destroying the malignant cells without inflicting major destruction upon adjacent healthy tissue.

In a cross-section of 821 cases taken from one clinic's records, 60 per cent of all the cases were treated by surgical procedures alone. Another 23 per cent had surgery as the major procedure, and this was supplemented with radium or x-ray, so that well over 80 per cent are to be considered primarily surgical cases. X-ray, radium, and x-ray and radium jointly were only used in 8 per cent of all the cases with the hope of achieving cure, and they were used in the other 9 per cent merely as palliative measures.

The fact that surgery and nursing care go hand in hand is another reason that the role of the nurse figures large in the care of the cancer patient.

Outside of the hospital walls the nurse's first responsibility is to prevent as many people as possible from becoming terminal cancer patients through promoting early detection of the disease by every known means. By being alert for symptoms which may possibly mean cancer in those whom she contacts, and by opening the way to early and adequate investigation of such symptoms she can do much, but her greatest scope lies in the field of education. While opportunities in this field come to every nurse, the greater number come to the public health nurse.

All public health nurses who have worked in rural areas will be thoroughly familiar with the fact that opening gates was one of the first things she had to become accustomed to in getting around her district. Public health nursing is a continuous series of opening gates, gates to more healthful living, letting down the bars of fear and misunderstanding which cause so much preventable illness and so many premature deaths. Every nurse should be a teacher, but the public health nurse *must* be a teacher. Only through effective teaching can she hope to change attitudes which are constantly in the way of achieving maximum conditions of positive health. This is true in relation to all of her work, but it is particularly true in regard to the field of cancer, the main reasons being: the insidious onset of the disease, firmly rooted false beliefs, and, most important of all, the fact that today cancer cannot be treated successfully unless it is treated early. It is estimated very conservatively that at least 25 per cent of present cancer deaths could be prevented if everyone knew enough about the disease to realize when it is necessary to seek medical aid.

People must be taught the facts if they are to deal with this problem to their best personal advantage. If they are to believe that it is possible to be treated successfully for cancer, and if they are to understand why treatment must take place early, they must know something about the nature of the disease. Dangerous false beliefs must be replaced by factual knowledge. There is little use telling people that many cancers can be cured, that there are many needless deaths from this disease, unless we make them understand why this statement is true and show them the important part which they have to play. They must be made to realize that the first responsibility lies with the individual, that unless the individual consults his doctor before the disease becomes advanced, with present day knowledge, his doctor is powerless to help him. Next to the family doctor it would seem that no one is in a better position to impart the necessary information to the people than the public health nurse. Because of the nature of her training and experience she is uniquely fitted to inspire confidence in her opinion and is also equipped to discuss the highly personal matters often involved.

There are two chief methods of teaching open to the public health nurse: the first is individual or person to person; the second is group teaching. Both methods have their merits but the first, or individual, is usually the more effective. The nurse has many opportunities to carry out this kind of teaching as she goes about her work. For example, when she makes a birth-registration visit she has an opportunity to discuss the importance of the postpartum examination and prompt repair of any birth injury. The child health clinic provides a similar opportunity to discuss this point. Women need to be taught that excessive or unexplained bleeding always requires investigation. The need for alertness for a lump or other suspicious changes in the breasts must be stressed. There will be ample opportunities to discuss the value of adequate mouth hygiene as it relates to the prevention of cancerous conditions of the buccal cavity. The hazards of taking home remedies constantly to allay "indigestion" instead of having a thorough investigation made can be explained. The possible meaning of changes in the appearance of a mole or wart should be pointed out at every opportunity. It isn't necessary to go into further detail — the nurse who is truly "cancer conscious" will find opportunities crowding in, one upon another, to teach the important facts about the disease.

The manner in which the nurse imparts information is important. She should be frank, adhering strictly to factual and well-authorized information but should always try to stress the reasons for optimism. Certainly, pessimism has been overworked in this field and actually is responsible for many deaths today. The excessively long average period of delay between onset of symptoms and the patient's first consultation with his doctor is frequently due to this pessimism. It should be stressed that the mild symptoms which may mean cancer, more often than not do not mean cancer. But it should be made very plain that the only way to find out is by having a thorough examination made.

Group teaching falls into two main classes: firstly, the small groups made up of members of a single organization, for example, a Mothers' Club, a Women's Institute, and numerous similar groups; and, secondly, the large public meeting. A great deal can be accomplished with the small groups because the members are usually acquainted and so discussion is spontaneous.

The chief reason for the large general public meeting is to cover a large number of people at one time. It is desirable to have a local doctor assist with large meetings if at all possible. Usually they are arranged under the sponsorship of some local committee or organization. The medical speaker should be chosen by the members of the sponsoring group.

Good films are exceedingly helpful at all meetings.

Only through an understanding of what is being done, and what the plans, hopes, and needs for the future are, will the confidence and support of the public be maintained, and the confidence and support of the public must be maintained if progress is to be made. It is part of the nurse's responsibility to see that the needs are interpreted to the people.

Another avenue through which the public health nurse can influence progress in cancer education is the high school. It is now agreed by practically all authorities, in the field of education as well as health, that the high school students offer one of the most promising fields for cancer education. Books on this subject suitable for high schools are now being introduced.

We cannot conclude a discussion concerning education for the early detection of cancer without mentioning the value of the regular thorough health examination. We are fully cognizant of the difficulties which this matter projects in the minds of a great many of our people, both lay and professional. Despite this, however, the fact remains that, if we are to make the best possible use of the knowledge which is available today concerning the control of this disease, we must utilize this tool. As long as it is necessary to find cancer early to treat the patient successfully does it not seem that the health examination should be considered a practical procedure in the field of cancer control?

The other services which the nurse is able to render in the field of cancer do not differ greatly from her work in relation to most other conditions. Persons who have been treated for cancer require close observation for a long time. It is frequently the public health nurse's job to convince the patient of the necessity for returning to his doctor for follow-up examinations and helping him to circumvent obstacles such as financial problems which prevent him from co-operating fully. Through helping to keep the patients under observation, the nurse is also assisting with the collection of valuable statistical data.

Occasionally, through lack of understanding, persons receiving deep x-ray therapy decide to discontinue the treatment before the course has been completed. Usually, these persons have had some reaction to the x-radiation and do not understand the value of enduring some temporary discomfort in order to safeguard themselves, insofar as is possible, against much more severe suffering. The public health nurse can frequently seek out these people and help them to appreciate the facts.

Finally, there is the service to the cancer patient in the home. Here the private duty nurse is able to make a great contribution, perhaps even greater than in the hospital, because she has a better opportunity to sense the difficulties and problems of both the patient and his family and through this better understanding is often able to be of greater help. The public health nurse, too, has many opportunities to be of assistance to the cancer patient in the home by carrying out bedside care on a visiting basis, by teaching some member of the family or household the correct care of the patient, and by assisting with the solution of any problems which obviously need her help.

An Instructors' Group Holds a Psychiatric Institute

Last year, the Instructors' Group of Alberta attended a two-day psychiatric institute at Ponoka Mental Hospital. The attendance was excellent as seventeen instructors from hospitals in the north and south of the province were present.

When programs of the proposed schedule of activities for the two days were given to us, we found we were going to see everything, hear everything, and experience everything that the hospital and staff could offer — and so it proved to be.

Under the leadership of Miss Mildred Nelson, instructor of nurses, and Miss Nessa Leckie, assistant instructor, we were conducted on a tour that took us to representative sections of the hospital. Here, in pleasant, cheerful surroundings, we saw many patients (the hospital has well over a thousand) sewing, reading, knitting, playing cards, or listening to the radio in the large comfortable sitting-room.

Many of the patients take a much more active interest in their surroundings, as a great number were seen everywhere busily sweeping, dusting, cleaning rooms, and working in the kitchens, laundry, sewing-room, bakery, and printshop.

Our visit to the occupational therapy studios was particularly interesting. In fact, our guides had some difficulty in getting us to leave. Here we saw patients making intricate and delicate wood-carvings furniture, weaving cloth, and cutting and stitching leather articles. I think we were all rather regretful when it was time to leave such a happy and cheerful assembly.

The visit to the treatment wards was especially educational. There we saw patients undergoing electric shock therapy, hydrotherapy, and malarial fever treatments. Conversations with some of the patients were interesting and enlightening. Many of them say they feel so much better following their electric shock treatments and that this newer treatment is much to be preferred to other types of shock treatments.

Subsequent tours gave us glimpses of the "stores," the dental office for the care of the patients, the admitting office, the medical library, the conference room, where patients are periodically interviewed and examined, the patients' library and canteen which are operated by the patients, under the supervision of the occupational therapist. Last but not least, we saw the beauty parlor in full operation. The staff is unanimous in declaring that this beauty parlor is of prime importance in establishing and maintaining personal pride in appearance, and raising the morale of the female patients. We all know what a wave after a shampoo does for us!

The group also attended several very interesting and informative lectures. These were presented in such a way as to give us much needed information, and roused so much interest that many in the group declared that working in a mental hospital such as Ponoka would be a very pleasant experience. The institute drew to a close with an appetizing and beautifully arranged buffet supper, which was enjoyed by all.

As the instructors of the group have long felt the need for a better understanding of psychiatric nursing and of psychiatric institutions, we feel that after having attended this two-day course we at least have a better appreciation of the value of such a training for all nurses. We are now looking forward to the day when the schools of nursing in Alberta will have affiliations with psychiatric hospitals, in order that the student nurses may have a more complete training in the profession of nursing.

Take it Off ! ! !

DOROTHEA LAKE

At the spring meeting of the Committee on Instruction, District 5, R.N.A.O., it was requested by the committee that cultures be taken of various types of watches and rings — jewellery worn on duty by nurses doing bedside care. Appealing to the nurse to remove the glamour from her uniform has not been effective, and it was thought that by having such experiments carried out, and by making the results known, nurses would become more conscious of good medical asepsis.

Preliminary experiments were conducted on the problem of cross infection by contaminated rings and watches in the wards of the Toronto General Hospital. Five student nurses were chosen from each of — the medical department, the surgical department, and the Burnside obstetrical department. Each of these students was instructed to wear a watch and a ring on duty the following day. After morning care was completed, cultures were taken of the watches and rings, care being taken not to touch the skin. Each nurse then washed her hands thoroughly, not scrubbing, and a second culture was taken. The cultures were delivered to the Banting Institute and planted immediately. The results showed that rings and watches carry similar bacteria to those present on the skin, and even when the hands were thoroughly washed only a few colonies of bacteria were destroyed.

Dr. Philip Greey requested that the experiments be repeated and that Dr. Alice Gray accompany the nurses and do a direct planting of the culture to prevent contamination and to give a more accurate picture.

On an appointed day cultures were again taken from nurses working in the same departments as before. These nurses carried out routine duties on the ward until ten o'clock. At this time cultures were taken with moist swabs and planted directly on blood agar plates. After the nurses had washed their hands, a second culture was taken and planted as before. On examination it was found that *Staphylococcus albus* and *Staph. aureus* were present on every plate but one, while aerobic spore-bearing bacilli occurred on about half of the cultures. The bacterial flora on the jewellery of dressing nurses varied little from that on the rings and watches of nurses concerned only with bedside care.

Similar experiments to the above were carried out at Wellesley Hospital, Toronto, and at the Toronto Hospital for Consumptives, Weston, with essentially the same results.

The foregoing experiments should provide sufficient evidence for nurses to refrain from adding jewellery to an already attractive uniform.

Wear the glamour with your civvies!

—*The Quarterly*, published by the Alumnae Association of the Toronto General Hospital.

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

The Use of the Volunteer Worker in a Public Health Nursing Service

KATHERINE BARR

DURING THE WAR YEARS, the City of Winnipeg Health Department, like most other community agencies throughout Canada, encountered the difficulties resulting from shortage of personnel, frequent changes of staff, heavy case loads, enlarged districts, not to mention the added duties which an expanding health program brought into being.

To meet community needs and to enable trained personnel to make better use of their special preparation, the assistance of the volunteer worker was sought on many occasions. Now that we are in the long talked of post-war period, now that we have had the time and opportunity to evaluate the contribution of the volunteer worker in the health program, we appreciate the fact that without such assistance, we would, no doubt, have fallen short in supplying the health services which the people in our local communities needed and expected.

While volunteers have from time to time ably assisted with mass toxoid surveys in schools, mass x-ray surveys of business firms, industries and high schools, and in various clerical duties; they have, perhaps, made their most outstanding contribution in our child health centres.

Weekly, in twelve child health centres located in various areas of the city, volunteers engage in certain specified duties:

> Weighing and measuring of infants and preschool children; recording weights and filing records; directing mothers to nurses or doctors, in turn, thus facilitating the smooth running of the clinic; helping nurses to set up the clinic; assisting the physician on immunization day; supervising and playing with children while mothers are attending classes in child care.

A public health nurse is responsible for interpreting the objectives of the services and for outlining and explaining the duties of the volunteers at that particular centre. As far as possible we have tried to adopt a system of rotation of duties so that each volunteer will have a variety of interests within the centre and in this way will not become attached to any one experience which she might tend to monopolize as her own particular field.

Volunteers come to our agency through the Central Volunteer Bureau. From time to time the public health nurse in charge of the child health centres is asked to send to the bureau a report of the work of the volunteer. Such things as regularity of attendance, promptness, efficiency in assigned tasks, special interests and abilities are noted. This is not done with a view to criticizing or chastising the volunteer, but rather as a means of placing each volunteer in a job which she can do well and at the same time experience that degree of personal satisfaction which is, in the long run, the volunteer's only reward for her efforts.

Realizing that the satisfaction of work well done is the volunteer's only gain, our department has tried from time to time to show its appreciation in a tangible way. Shortly after the initiating of the volunteer workers into our program, the Health Committee of the City Council held an evening reception in their honor. However, more successful than a large gathering, we have found that an invitation to an office tea party, a few kindly words at the end of the day, a short letter of thanks when a volunteer leaves the service, help to stimulate that feeling of worthwhileness in the tasks performed.

In evaluating the reaction of our volunteers to the work which they have done and are doing so faithfully at present, we have discovered that the whole experience is a two-way process. While volunteers have a service to offer, a contribution to make, they are not the kind of people who are able to appreciate passively what they see, hear and feel at a child health centre. They take their experiences home with them. They are influential in bringing about in their communities a better understanding of the principles of public health. They have an opportunity to do a real job of citizen education.

Organizing a Well Baby Clinic

MAY G. DOUGLAS

SMITHERS, B.C., with a population of 951, is situated approximately midway between Prince Rupert and Prince George on the northern line of the Canadian National Railways. Built for the most part on muskeg, the town's sewage and drainage facilities present a marked problem to the householder. Improper drainage constantly endangers the water supply, which is at present each individual's responsibility in his own home. Water is procured by driving a sandpoint into the ground and attaching to it an electric pump or a hand pump.

With the above disadvantages one would presume that the average rate of sickness, per capita, due to the consumption of a dubious water supply, would be much higher than in a town built on a more suitable location. This, however, is not the case. There is no record of any serious epidemic in Smithers and, apart from bi-annual gastro-intestinal upsets, facetiously termed "Ditch Fever," the children are average, and sometimes better than average, in health.

The Smithers Chapter of the Registered Nurses' Association of British Columbia, formed in 1944, is comprised of seventeen members, the majority of whom are wives and mothers. In October, 1944, due to the absence of a public health unit to serve Smithers and the large surrounding district, it was decided that our Chapter would take upon itself the onus of founding and operating a well baby clinic.

By correspondence, we received expert advice and willing co-operation from Miss Dorothy Tate, R.N., director of public health nursing with the B.C. Provincial Board of Health. Plans went forward to raise our own funds and acquire suitable equipment to enable us to open our clinic in the first month of 1945. Our first few clinics were held in the Municipal Hall on the first Saturday in the month and one, in the office of Dr. L. M. Greene, on the third

Wednesday in the same month from 2.30 to 4.00 p.m. These days and locations were so designated to accommodate farmers from the outlying districts and to utilize the only space available to us at the time. The confusion resulting from two locations and two dates has since been eliminated by holding the clinic once monthly in the doctor's office. We find the farmers' wives sufficiently interested to make an effort to be in town for "Clinic Day."

Service in the clinic is supplied by the Chapter members who attend in groups of three, three times in succession, alternating so that at least one of the nurses present has attended the previous clinic. We find this system excellent, inasmuch as any problems brought up at a clinic may be dealt with, if necessary, by a person acquainted with the problem, at the following clinic. In this way, too, the mothers acquire confidence in not having to explain to, and ask advice of, a new nurse at each clinic.

The equipment required to operate is: one pair of baby scales; one large table for stripping the babies; an adequate supply of paper tray-covers to be placed atop oilcloth pads on which to examine babies; one filing box with individual cards for each child's clinical record; three white laboratory coats for nurses in attendance; a generous supply of literature procured from the provincial health department.

The chief service given the public through our clinic is immunization. Our average attendance is twelve babies, but we have had as many as thirty-five and as few as seven in attendance.

Our advice to the mothers is kept wholly within the realm of professional ethics and, although we have no doctor in attendance, we refer the mother, when necessary, to the local practitioner during his office hours. We presented our clinic to the public through our advertisement in the local newspaper and fostered attendance by personal calls and word of mouth. The new mothers in hospital are approached by the nurse on duty, and given a cordial invitation to bring the baby to clinic. We have discussed, and plan to execute a system, whereby each mother in hospital is presented with a suitable personal card from our clinic inviting her infant to attend.

We feel our clinic is a success. It fills a great need in our community and we meet with co-operation and gratitude throughout Smithers and its surrounding rural districts. Only the excellent work of each one of our members enables us to carry on our project, for we receive no financial assistance from any group or organization. None of our members has received special training in public health work, but each has had to learn, through applying herself, and, of course, through trial and error, to adapt herself to the public's needs.

Health Week—1947

The Health Week program of February, 1946, promoted by the Health League of Canada, was remarkably successful, owing to the fine co-operation of the nine provincial Departments of Education and of Health, the schools, churches, Home and School Associations, women's institutes, service clubs and other groups, press, radio, and film. The Health League of Canada is planning a more comprehensive Health Week campaign for February 2-8, 1947, with National Social Hygiene Day set for February 5. It is hoped that all organizations interested in any way in the improvement of personal and public health will join in this movement.

Health is so fundamental for individuals and communities that it is good citizenship to do anything to promote better health. A Canada with ' optimum" health would lead the world in this great national asset. The Health League of Canada earnestly requests your co-operation in making known and supporting this Health Week Campaign. Help with your community's program.

A Vital Memorial

What would our world be like without books? Can you imagine yourself stripped of every piece of reading material? You would very shortly feel lost. How could you keep up with everyday events, with the serious things of life as well as the frivolous without books and magazines? Can you visualize yourself teaching student nurses without textbooks or nursing journals?

That is briefly the plight in which thousands of our colleagues have been finding themselves for the past few years. The libraries in the countries most grievously hit by the war, no matter what libraries they were, have been demolished to a great extent. There are schools of nursing in all of these countries — many of them have no textbooks at all! In some instances, they were all lost through the saturation bombings that took no account of any possessions. Others were destroyed by the enemy who occupied the areas. There is practically nothing the nurses can use.

Nurses in many lands had not written textbooks as they do in the countries with which we are familiar. Even before the war, it was necessary to provide them from outside sources. Now there is little paper available in Europe or in China for the printing of textbooks. The need, therefore, is enormous.

As a living, vital memorial to our nursing sisters of World War II, the Canadian Nurses' Association at its last biennial meeting endorsed the proposal that libraries be assembled and presented to the nurses in foreign lands. Books are expensive, both to purchase and to ship, so a large sum of money must be collected. It is proposed to stage a campaign all across Canada from January 1 to May 1 with the objective of raising $32,000. You will be asked to contribute. Let your gratitude for our unscathed land be your guide in considering the size of your donation. A minimum of one dollar per nurse would enable us quickly and painlessly to reach our objective.

Obituaries

Frances Adelaide Acres, aged 20, died recently following a serious illness. Miss Acres was a student nurse at the Cornwall General Hospital, Ont.

Maria Fillmore, who was matron of the Provincial Mental Hospital, New Westminster, B.C., from 1897 until her retirement in 1939, died recently at the age of eighty-seven years. A native of Cumberland County, N.S., Miss Fillmore received her training at the Worcester (Mass.) Mental Hospital. She began working in New Westminster in 1893.

Josephine Hamilton, who had the distinction of being the first graduate of the Hospital for Sick Children, Toronto, died on November 7, 1946, after being active in nursing for more than half a century. Though she had retired, Miss Hamilton returned to professional activity during World War II when in 1943, shortly after she had celebrated her seventy-third birthday, she worked on the nurses' registry.

Helen Joyce Davidson, who was a graduate of St. John's Hospital and the University of Toronto School of Nursing, died on November 12, 1946. She had been in ill health for the past two years.

Miss Davidson served for four years as superintendent of the Toronto West End Creche and for eight years as visiting nurse for the Infants' Home. Later she joined the staff of the Toronto Department of Public Health.

Olive Young Rand, who was born in Canning, N.S., graduated from Royal Victoria Hospital, Montreal, and who spent most of her professional life in the United States, died on October 2, 1946. Miss Rand enlisted in the U.S. Army Nurse Corps in 1942. She served in France with the First General Hospital until after V-E Day. She is buried in Arlington Cemetery, Washington, D.C.

Margaret Zimmerman, who graduated from the Brantford General Hospital, Ont., in 1929, died suddenly in Noranda, P.Q., where she had been engaged in nursing since 1937.

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Orientation of the Private Duty and General Duty Nurse

MILDRED KOCH

THE IDEA WAS CONCEIVED in the mind of a private duty nurse. It was a healthy idea, for it grew day by day as she nursed in a strange hospital. Surely something could be done to help her feel less strange and helpless.

The idea took greater magnitude the morning that her patient, who had pneumonia, became very cyanosed and the need for oxygen and a respiratory stimulant was urgent. Where would she find the oxygen? Where were the stimulants kept? In fact—where was the head nurse? She was not in the chart room—Oh yes, there she was, taking a pre-operative to surgery and the tail of her uniform could be seen as she eased into the elevator. Yes, indeed, there was a need for some form of orientation, and a concise form, for the private duty nurse in this new hospital situation.

The idea of an orientation plan was conceived in the mind of a private duty nurse but the idea was born over a bottle of soft drink, when a general duty nurse, thinking along the same lines, added her miseries to those of the private duty nurse. She, too, had experienced the same confusion when she had recently taken a position on the staff of a hospital.

So, at the birth of the problem child, the general duty nurse and private duty nurse turned their "baby" over to the care of the Hospital and School of Nursing Section of the Manitoba Association of Registered Nurses.

The problem was voiced, discussed, and solved at a meeting of the above section last spring. The presentation took the form of a dialogue forum which is here presented, followed by the solution which transpired as a result:

P.D. Miss R, you have recently taken a new position as general duty nurse at X Hospital. You probably have some ideas which will help us in discussing your adaptation to the new situation.

G.D. One of my biggest problems was becoming adjusted to the ward routine. I found that I could plan and arrange my work more effectively after I had gained working knowledge of the daily schedule of the ward. I feel that a definite plan made and presented to the new nurse when she comes to the ward would help overcome this difficulty.

P.D. What specifically do you mean by this "definite plan?"

G.D. I thought of either a typed copy of the ward routine to be posted in a conspicuous place or a ward manual which contained that plan. In your role as a private duty nurse, does this problem confront you?

P.D. Actually, the ward routine does not touch me as much as it would you but I think the private duty nurse sometimes forgets that her patient is, indeed, a part of the ward and that she is responsible to the supervisor for the care of her patient. My biggest problem was that of registering. Some hospitals seem quite lax about registering; others are very upset when you do not register the moment you report on a case. I can see where, in a large hospital, at least, this is very necessary. But the biggest obstacle was where to register. In some hospitals one registers in the T.S.O., in others in the business office. If only one knew where to register so that valuable time would not be wasted going from one office to the other! Another big help would be for a member of the T.S.O. to conduct the private duty nurse to the ward and introduce her to the supervisor. This is especially helpful when the private duty nurse has never been in the hospital before.

G.D. No, I don't think that the administrators can afford to take the time for this.

P.D. Yet the administrators expect the private duty nurse to cooperate in ward routine. I think the proper introduction to the supervisors would promote this feeling of co-operation.

G.D. I think that in order to get an idea of the plans the supervisor could make for the orientation of the new nurse to her ward, we should follow the new graduate from the time she enters the ward. The first thing that is necessary is a proper introduction to the personnel she will encounter and an explanation given of their duties on the ward. Then, a trip around the ward to familiarize her with its general plan would be advisable.

P.D. I found that the whereabouts of the linen cupboard, extra blankets, pillows and rubber goods, is of primary importance. The distribution of the supply of linen is controlled in some hospitals, while in others it is not. I found also that in some hospitals the linen came up from the laundry shortly after dinner and was distributed at this time to the various patients' bedsides. If one wasn't at the linen cupboard at the appointed time, an unhappy situation developed. My criticism here is not the method of distribution but the fact that the method is not known by a stranger.

G.D. The problem regarding the distribution of linen also applies to the general duty nurse, in that she should know where she may obtain supplies in cases of emergency. She should also be acquainted with the necessary requisitions for obtaining such supplies.

P.D. The immediate problem of a private duty nurse is the location of the drugs. The narcotics are often needed for pre-operative medication as soon as she comes on in the morning. Where to find these drugs quickly and the necessary requisitions and bookkeeping involved are her immediate concern.

G.D. Is this as important a question in the introduction of a general duty nurse? Are her needs in this respect as urgent?

P.D. The dressing facilities in various hospitals differ widely. In some hospitals there is a complete central dressing room; in others, some of the materials come from a central dressing room, the rest from the ward supply; and, again, some hospitals have the complete dressing facilities on the ward. When the doctor comes, the private duty nurse does not know where she may find her dressing equipment.

G.D. That brings up the point—should the general duty nurse be taught the standard nursing procedures of the hospital so that she may be competent in setting up the dressing trays in the manner followed by the hospital? If it is a training school she must know as she is a potential teacher.

P.D. This brings up the problem of emergency equipment such as oxygen tanks, suction apparatus, etc. This information is as important to the private duty nurse as is the availability of the drugs.

G.D. To the general duty nurse, this can be a slower introduction and may be taken in during the tour of the hospital where the laboratory is introduced and the location of the main depots are pointed out to her. This is very important in the orientation of the general duty nurse and should be included in the plan by the supervisor of the ward. The next point that seems to be important is that the general duty nurse must know the location and facilities of the diet kitchen and distribution of the diets.

P.D. The distribution of diets is quite varied. In some hospitals they have central diet kitchens; in others, part of the diet comes from the diet kitchen and the remainder from the ward. In most hospitals the private duty nurse prepares her tray prior to or immediately after the ward diet. However, in other hospitals, the complete tray is distributed by the diet kitchen. This causes considerable confusion to the strange private duty nurse unless she is thoroughly familiarized with the dietary routine.

G.D. In order to make the general duty nurse feel more at home, the supervisor should arrange for someone to accompany her to the first meal.

P.D. Often the private duty nurse does not eat in the hospital because no one introduces her to the hospital dining-room or the means by which she may obtain meals.

G.D. As a final point I would like to state that the general duty nurse should be made acquainted with the rules of procedure regarding calling doctors in the event of a serious turn in the patient's condition.

The topic was then left to the meeting for discussion. The problems were solved as follows:

1. A well-planned orientation should be carried out for the general duty nurse taking a position in a new hospital. Such a plan should extend over a fair period of time.
2. A concise chart with the geography of the hospital and the ward should be placed in a conspicuous place on each ward. Such a chart should point out clearly the location of emergency depots.
3. It was felt that the Nurses' Directory could tell the private duty nurse where to register in the hospital, when the nurse is called on the case.
4. It was also felt that it was the duty of the private duty nurse to introduce herself to the ward personnel.
5. A card explaining the laundry rules, time of distribution, etc., could be tacked to the linen cupboard door or conveniently placed within the linen cupboard.
6. A similar card in the ward kitchen would prepare the private duty nurse for the method of distribution of diets.
7. Someone on the ward, if not the supervisor, should be appointed to direct the general duty nurse and private duty nurse, if she so desires, to the dining-room.

Victorian Order of Nurses for Canada

The following are the recent appointments to, transfers, and resignations from the various branches of the Victorian Order of Nurses for Canada:

Appointments: *Dorothy Geeson* (University of Alberta Hospital and University of Alberta public health course) to Edmonton; *Marjorie McIntosh*, who received a Victorian Order scholarship and has completed the public health course at University of Toronto, as nurse-in-charge at Aurora; *Elsie Waller* (Hamilton General Hospital and University of Toronto public health course) to Hamilton; *Mrs. Libbie Rutherford* (Montreal General Hospital and University of Toronto public health course), recently returned from overseas service with UNRRA, to Toronto.

Transfers: *Dorothy King* from Orillia to be nurse-in-charge at Brantford.

Resignations: *Maude Tisdale* from Toronto to be married; *Mabel Russell* from North Vancouver; *Edith McLean* from Calgary; *Elizabeth Jenkins* from Vancouver to be married; *Margaret Janzen* on leave of absence from Toronto.

M.L.I.C. Nursing Service

The following are recent changes of staff occurring in the Nursing Service of the Metropolitan Life Insurance Company:

Appointments: *Apolline Coursol* (Hotel Dieu Hospital, Montreal), *Alphonsine Lemay* (St. Michel Archange Hospital, Quebec City), *Rose Theberge* (Hôpital de l'Enfant Jésus, Quebec City), *Antoinette Vachon* (Hôpital de l'Enfant Jésus, Quebec City), to Montreal staff.

Transfers: *Cecile Leclerc* (Saint Jean de Dieu Hospital, Gamelin), *Fernande Duclos* (St. Sacrement Hospital, Quebec City), *Antoinette Richard* (St. François d'Assise Hospital, Quebec City), *Pauline de Villers* (Notre Dame Hospital, Montreal, and University of Montreal public health course) from Montreal to Quebec City staff.

Resignations: *Marguerite Ouellet* (Hôpital de l'Enfant Jésus, Quebec City) and *Jeanne Brais* (Montreal General Hospital) from Montreal staff.

Gertrude Gouin (Notre Dame Hospital Montreal, and University of Montreal public health course) has resumed her duties on the Montreal staff after a leave of absence to join the R.C.A.M.C. in August, 1942. *Adrienne St. Onge* (Misericordia General Hospital, New York City) has resumed her duties on the Montreal staff.

Ontario Public Health Nursing Service

The following are the staff appointments to and resignations from the Ontario Public Health Nursing Service:

Appointments: *Mrs. Noreen Heath* (Royal Southern Hospital, Liverpool, Eng., and University of Pennsylvania public health course) to Bruce County health unit; *Alice Klugman* (Toronto Western Hospital and University of Western Ontario certificate course), formerly with Chatham Board of Health, to Guelph Board of Health; *Mrs. Bertha Young* (Ottawa Civic Hospital and University of Western Ontario certificate course) to Prescott Board of Health; *Mrs. Isabel Gleason* (Hamilton General Hospital and University of Toronto certificate course) to Haileybury Board of Health; *Kathleen Bayley* (Ottawa General Hospital and University of Ottawa certificate course) and *Gladys Clark* (Ottawa General Hospital and University of Ottawa certificate course) to Ottawa Board of Health.

Resignations: *Mildred Haberer* (Stratford General Hospital and University of Western Ontario certificate course) from Huron County school health service; *Mrs. William (Walker) MacDougall* (St. Joseph's Hospital, Toronto, and Ontario Department of Education summer course in school nursing) as supervisor of public health nursing, York Township Board of Health; *Marguerite Court* (St. Michael's Hospital, Toronto, and Ontario Department of Education summer course in school nursing) from Sudbury separate school board; *Elizabeth Ryan* (St. Joseph's Hospital, London, and University of Western Ontario certificate course) from Lambton health unit; *Elsie Wright* (McKellar General Hospital, Fort William, and University of Toronto certificate course) from Port Arthur Board of Health.

Prize Winners

The decisions of judges selected to evaluate the entries in the *Journal's* 1946 article contest were received in time to forward the prizes to the contestants in time for their Christmas shopping forays. Each chose to write on the topic "Bedside Nursing — an Essential Service." Our congratulations go to the winners of these awards, who were:

First prize: Miss C. E. M. Rowles, Industrial Nurse, Dominion Glass Co. Ltd., Redcliff, Alberta.

Second prize: Miss Christine E. Charter, Vancouver, B.C.

The limited number of entries means one of two things — either the nurses of Canada are not interested in article contests or they found the topics unsuitable for their writing talents both in 1945 and 1946. Which was it? The Editorial Board and the editor would be interested in receiving answers to these queries. Do you wish to have an article contest in 1947? What topics do you suggest? Address your letters to: *The Canadian Nurse*, 522 Medical Arts Building, 1538 Sherbrooke St., W., Montreal 25, P.Q.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

Le Lit Orthopédique

SOEUR MARIE-AUXILIATRICE, O.S.A.

DESCRIPTION

LE LIT LUI-MEME est le lit simple d'hôpital sauf qu'il est un peu plus long; il doit mesurer sept pieds. Il requiert un matelas ferme, sous lequel on glisse une planche dans la plupart des cas afin de le maintenir rigide.

L'appareil orthopédique, que l'on peut adapter à tous les lits, est pourvu de différents accessoires de manipulation très facile. La charpente comprend deux supports de fer maintenus par des traverses de bois et fixés au lit au moyen de courroies de cuir. Détail pratique: à leur partie supérieure, ces supports sont légèrement incurvés pour éviter de détériorer le mur en déplaçant le lit.

Sur cette charpente viennent s'ajuster les accessoires. Le plus important est le cadre "Bradford,"* genre de brancard. Sur le cadre lui-même sont fixés deux bandes d'un canevas spécial, retenues à chaque extrémité et au centre par des lacets de cuir pour les maintenir bien tendues. Ces quatre tubes de fer peuvent être facilement désunis, pour nous permettre de retirer les canevas pour la lessive. Des cordes, retenues par quatre crochets, supportent le brancard et permettent le jeu de poulies doubles, qu'une simple manette fait mouvoir.

Un trapèze, placé à portée de la main du malade, est suspendu aux traverses de bois sur lesquelles sont fixées des poulies, selon les besoins.

Une autre barre transversale, munie d'une poulie, peut fort bien s'ajouter au pied; elle servira pour faire l'extension d'un membre inférieur.

AVANTAGES

Ce lit offre de précieux avantages tant à la garde-malade qu'au malade lui-même.

Les fractures de la colonne et du bassin sont assurément les cas qui présentent le plus de difficultés et qui bénéficieront surtout de ce lit; aussi bien que tout opéré à la suite d'une intervention sur la colonne soit greffe ou laminectomie.

Le premier avantage est celui du cadre "Bradford," et il est pour le malade. Il lui évitera des mouvements douloureux, soit au cours des soins quotidiens, d'un traitement, soit pour son déplacement du lit sur la civière, s'il s'agit d'examens radiologiques ou autres. Il suffit de décrocher et de glisser le cadre sur le véhicule. La position du malade n'a pas changé et il n'a subi aucun contrecoup.

L'infirmière dépense ses forces et se voit malgré tout obligée de lancer un S.O.S. Ici, sa tâche est bien diminuée. J'ai moi-même soulevé une malade immobilisée, pesant environ 170 livres, sans dépenser deux calories. Juste un petit coup de manette et tout était fait.

TECHNIQUE

Pendant qu'un malade est à la salle d'opération, l'infirmière s'occupe de faire placer le cadre sur la voiture qui doit le ramener à son lit. Après l'intervention, le malade y sera déposé avec toutes les précautions nécessaires par le personnel de la chirurgie. Sa position maintenant définitive rassurera l'orthopédiste.

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*Pour catalogue s'adresser à Zimmer ou De Puy, Warsaw, Indiana, U.S.A.

Pour les cas de fracture de la colonne et de mal de Pott, le cadre n'a plus son plan horizontal droit, mais il présente une convexité au niveau de la région dorso-lombaire, afin de maintenir le malade en hyperextension dorsale.

Pour diminuer la pression sur le matelas et prévenir les plaies de décubitus, on place sur ce brancard spécial deux coussins faits de coton hydrophile recouverts de gaze. Ces coussins sont protégés par deux alèzes. Dans les cas de greffe de la colonne, ces alèzes serviront à mouvoir le patient dont la position doit varier aux six heures et toujours sans préjudice au succès du traitement.

Mais le malade n'est pas seul à bénéficier de cet appareil dont les avantages sont incontestables.

L'arrivée d'un cas de fracture de la colonne ou du bassin dans un de nos services de chirurgie rend perplexe la plupart de nos meilleures infirmières. Qui ne connait la difficulté des soins à donner, les dangers d'une immobilisation trop prolongée, et pardessus tout la crainte de nuire à la formation du cal osseux par des déplacements trop brusques? Rien que pour maintenir confortablement un membre fracturé dans la position requise, cela demande beaucoup d'habileté de la part de l'infirmière. Le lit orthopédique vient au secours des bonnes volontés. Il est l'auxiliaire le plus commode et le plus précieux. Son mécanisme, en assurant au malade un maximum de sécurité, facilite extraordinairement la tâche de l'infirmière. Le cadre "Bradford" laisse toute liberté pour les traitements, permet de donner des soins hygiéniques plus fréquents et plus suivis, grâce à l'espace ménagé au centre, entre les deux bandes de canevas.

L'entretien du lit est grandement simplifié, le malade étant isolé du lit au moyen du brancard. De plus, elle a la satisfaction de sentir qu'elle n'incommode ni ne fatigue son malade pendant tout le temps que durera le procédé.

Pour déplacer l'un de ces grands malades dans un lit ordinaire, il faut vraiment faire de l'acrobatie.

S'il s'agit de fracture du bassin, accident qui se rencontre souvent chez les personnes âgées, l'infirmière mettra tout en oeuvre pour entretenir les mouvements chez ces malades dont l'immobilisation prolongée favorise les stases et entraîne soit des complications pulmonaires, embolies ou autres. C'est ici que le trapèze prouve son utilité. Il permet au malade de prendre des positions confortables, de se supporter seul, de s'aider en maintes circonstances. Ce qui redonne du tonus musculaire, de la souplesse et fait disparaître les oedèmes en activant la circulation.

Chez un fracturé, immobilisé dans un plâtre, les mouvements étant nécessairement limités, l'infirmière suppléera à cette déficience en tournant le malade sur l'abdomen, une heure l'avant-midi et une heure l'après-midi.

On peut maintenir un membre soulevé, soit à l'aide de coussins ou encore en le suspendant par la poulie à la traverse, au moyen de bandes de canevas fixées préalablement dans le bandage plâtré par l'orthopédiste.

Dans les cas d'arthroplastie de la hanche et du genou, après l'enlèvement du plâtre, il faut procéder graduellement à la rééducation des mouvements. Un support, lequel placé sous le genou et maintenu par une corde munie d'une poignée, permet au malade des mouvements actifs de ses membres supérieurs et, comme conséquence, des mouvements passifs des membres inférieurs. Cet exercice aura pour effet indirect de combattre un état de dépression, compagnon fatal, souvent, des maladies longues, et de jouer le rôle d'occupation thérapeutique.

Il y aurait aussi intérêt à utiliser ces lits chez les paralysés et les impotents. Comme mesure prophylactique des plaies de décubitus chez les personnes maigres, on laissera entre le cadre et le lit un léger espace qui permettra d'y glisser des coussins.

Notes from National Office

International Council of Nurses

FOR THE FIRST TIME since 1937, the Quadrennial Congress of the International Council of Nurses will be held in Atlantic City, N.J., May 11-16, 1947, inclusive.

Previous to the Congress in Atlantic City, the Board of Directors and the Grand Council of the I.C.N. will meet in Washington, D.C., May 4-10, 1947. The Board of Directors will meet May 5 and 6 for a business meeting. Each member country is entitled to send the president of the national association to that meeting. Also, it is quite possible that the executive secretary of each national organization will be asked to attend, pending the decision made at the Board of Directors meeting held in London, in September, 1946. The president, treasurer, executive-secretary, and chairmen of all committees will make their reports at this meeting. Resolutions from national organizations should be placed on the agenda and, after the approval by the Board of Directors, will be transmitted to the Grand Council for adoption.

The Grand Council will meet May 7, 8, and 9. At this meeting, the election of international officers will take place—one president, three vice-presidents, and a treasurer. Reports from the Board of Directors will be presented. General policies and work for the next quadrennial period will be outlined. All national organizations will be asked to present reports on their activities not later than January 1, 1947, as they must be translated and printed to be at the disposal of the delegates.

The Grand Council consists of international officers, national presidents, and four official delegates from each country, and one delegate from associate national representatives. On May 10, all official delegates will leave Washington, D.C., for Atlantic City, N.J.

The Quadrennial Congress will take place in Atlantic City, starting Sunday, May 11, and will be opened by two church services—one Catholic, one Protestant. The rest of Sunday will be used for registration. The Congress will begin with a general meeting on Monday, May 12. More details about the program will be available at a later date from the American Nurses' Association, who is hostess to the International Congress.

On Saturday, May 17, the new Board of Directors, presided over by the newly-elected president, will have its first meeting.

The Swedish Nurses' Association has sent an invitation to the International Council of Nurses to hold its next meeting (following the Congress in 1947) in Stockholm.

All registered nurses are cordially invited to attend the meetings of the International Congress. Identification cards as registered nurses (or proof of membership in a national organization) will be the only document necessary to register for the Congress and to participate in all the activities. The number of registered nurses will not be limited. Student nurses are also invited. However, their number must be limited to one representative from each school of nursing. In addition to student nurses, who will be welcomed as special guests, a certain number of other special guests are invited, such as doctors, those in allied professions, and those especially interested in the nursing profession.

American Nurses' Association

Each person attending the biennial convention of the A.N.A. held in Atlantic City, N.J., September 23-27, will have her own story to tell, as it was quite impossible to take in all the meetings and conferences. The best we can do is to try to tell in our own way some of the highlights of the meetings.

Of far-reaching significance was the decisive vote by the House of Delegates, authorizing State and District Associations to act as exclusive collective bargaining agents for American nurses.

The report on the structure of organized nursing (see *A.J.N.* Oct. and Nov. 1946) was one of the most important items on the agenda. This is a long range program and nurses are urged to study and discuss the report since the implications of its two suggestions for the new structure are so far-reaching.

A great deal of the discussion of personnel policies and practices as related to nurses was of pertinent interest to all nurses. Not only was the necessity for written policies of salary, hours, work, and other activities discussed, but job analysis, recognition of tenure of office and for outstanding work was also fully discussed.

Fees were raised from 75 cents per capita to $3.00 per capita by more than two-thirds majority vote. The N.L.N.E. annual dues for individual membership were raised to $5.00.

The House of Delegates voted a revision of by-laws making proxy voting possible. In the future, elected delegates who are unable to attend the convention will have their personally marked ballots deposited in the ballot box at the convention by proxy, thus making it possible for a State Association to use all the ballots to which it is entitled.

The House of Delegates approved a motion: "That coloured nurses who are not eligible for membership in their State Nurses' Association be made eligible for membership in the A.N.A."

The president gave the following ten points as a suggested platform for the coming biennium:

1. Improvement in hours and living conditions for nurses, so that they may live a normal personal and professional life, specifically action toward: (a) Wider acceptance of the 40-hour week with no decrease of salary, thus applying to our post-war conditions the principle of the 8-hour day adopted by the American Nurses' Association in 1934. (b) Minimum salaries adequate to attract and hold nurses of quality, and to enable them to maintain standards of living comparable with other professions.

2. Provision for optimal nursing care for all, and furtherance of a positive health program in all communities.

3. Increased participation by nurses in the actual planning and in the administration of nursing service in hospitals and other types of employment.

4. Greater development of nurses' professional associations as exclusive spokesmen for nurses in all questions affecting their employment and economic security. Such a development should be based on past successful experience of professional nurses' organizations in collective bargaining and negotiation.

The economic security program referred by the A.N.A. Advisory Council (September 22,1946) to the A.N.A. House of Delegates follows:

"The American Nurses' Association believes that the several State and District Nurses' Associations are qualified to act and should act as the exclusive agents of their respective memberships in the important fields of economic security and collective bargaining. The association commends the excellent progress already made and urges all State and District Nurses' Associations to push such a program vigorously and expeditiously.

"Since it is the established policy of other groups, including unions, to permit membership in only one collective bargaining group, the association believes such policy to be sound for the State and District Nurses' Associations."

5. Removal, as rapidly as possible, of barriers that prevent the full employment and professional development of nurses belonging to minority racial groups.

6. Employment of well-qualified practical nurses and other auxiliary workers under state

licensure, thus protecting both the patient and the worker.

7. Continuing improvement in the counselling and placement of nurses, to give greater stability and job satisfaction to the profession and to facilitate a better distribution of nursing service to the public.

8. Further development of nursing in prepayment health and medical care plans, in order to spread the cost of nursing service to the public.

9. Maintenance of educational standards, and development of educational resources, that nursing may keep abreast of the rapid advances in medicine and other sciences. Such development may well require federal subsidies and contributions from foundations and other educational philanthropies.

10. Appraisal of our own national organizations, through the report of the Structure Study, and fearless action based upon such appraisal, to make sure that the nursing profession will be organized and equipped to deal most effectively with its problems and its opportunities.

In conclusion: If the nursing profession is ready to take decisive action on hours, salaries, economic advancement, enlargement of nursing resources while maintaining standards and the possible reconstruction of its own organizational structure, we shall have made nursing history this week.

Provincial Registered Nurses' Associations

Progress reports as presented at the Executive Meeting, C.N.A., December 5-7, 1946, follow:

Alberta Association of Registered Nurses: In Alberta, revision of the Alberta Registered Nurses Act has begun. The Educational Policy Committee has been appointed with Miss Helen Penhale as convener. The main topics that are being studied by this committee are: (a) The possibility of expanding affiliations for Alberta student nurses so as to include experience in tuberculosis and psychiatric hospitals and possibly in selected approved rural hospitals. (b) The possibility of a Central School of Nursing in order to increase the number of nurses graduating each year in Alberta and improve and facilitate the education of student nurses. (c) The arrangement of short courses in examination technique and relative matters.

A brief was prepared and sent to the Department of Health relating to the Alberta Health Insurance Act.

The instructors' group is revising the "Minimum Curriculum for Schools of Nursing in Alberta." One dollar per capita of the 1946 registration fee of five dollars is being used to assist in financing the nurse placement service.

Registered Nurses' Association of British Columbia: In British Columbia, the five larger schools obtained the number of students for which they planned, the two larger schools reporting more acceptable applicants than could be enrolled.

The present vacancies in public health, schools of nursing, hospitals and institutions amount to 439.

More than thirty employers have notified Placement Service that all or nearly all of the recommendations have been put into effect or are under consideration at the present time.

A series of bulletins on Employer-Employee Relationships for distribution to members of the nursing staff in hospitals, institutions, clinics, visiting nursing, and public health nursing agencies is being prepared by a sub-committee of the L.R. Committee.

A Joint Planning Committee on Nursing was organized in August representing the Departments of Education, Health and Welfare, Inspector of Hospitals, D.V.A., Medical and Hospital Associations, Community Chest and Welfare Council, and the R.N.A.B.C. A sub-committee was appointed to plan an activity analysis within hospitals and outline training courses. The chairman selected a fact-finding committee from hospital personnel to report on the type of non-professional workers now employed in hospitals: what duties are now being carried on by these workers and of what further duties could nurses be relieved.

The sub-committee was authorized to proceed to outline details of the training program.

Manitoba Association of Registered Nurses: In Manitoba, two nurse-members have been appointed to a committee set up by the Minister of Health and Public Welfare for the purpose of studying the "Training of nurses and the supplying of personnel suitable for rural hospitals."

An instructors' institute was held in June at the University of Manitoba. Discussion and revision of the content of courses tested in qualifying and registration examinations were the chief topics. Revisions were made in the curriculum outline for first year and senior students.

Deep concern was expressed at a meeting of the Joint Committee on Tuberculosis Nursing over the fact that registered nurses were not willing to do nursing in tuberculosis.

The *New Brunswick Association of Registered Nurses*, through the Committee of the Subsidiary Worker, seeks the support of selected community organizations in the proposed licensing of the subsidiary worker and urges that further study be made of the bill for licensing the subsidiary worker and that a special meeting of the executive council be called later to study and further implement the bill.

The annual membership fee was raised to $5.00.

A study of the proposed revision of the present Constitution and By-laws for the *Registered Nurses' Association of Nova Scotia* was authorized by the association to the incoming Legislative Committee.

It was proposed at the annual meeting that branches of the R.N.A.N.S. endeavor to form Public Health and Welfare forums in their localities for the purpose of stimulating interest and assisting in the solution of nursing problems.

The members of the *Prince Edward Island Registered Nurses Association* have already begun work on the revision and amendments to their Constitution and By-laws. Personnel practices and policies for the General Nursing Section have been prepared and a library established by the Public Health Group.

The main concern of the Committee of Management of the *Registered Nurses Association of the Province of Quebec* is the planning of all the various changes in policy and administration which the licensing Act calls for.

The Committee on Subsidiary Nurse Workers has held three meetings. As a result, a study committee has been organized for the purpose of submitting a license plan for consideration of the larger group.

The place of the subsidiary worker, etc., and present scales of staff salaries in hospitals were discussed at a meeting with representatives of the three hospital councils of the province. Fees have been raised to six dollars. It is generally understood that the increased activities of the labor syndicates, insofar as their endeavors to involve nurses are concerned, is due to the fact that, after December 31, 1946, nurses will be legally classed as professional workers.

The *Saskatchewan Registered Nurses' Association*, through the Joint Committee, is studying ways and means of securing cooperation in directing the efforts of the registered nurse to professional duties only, of securing more professional nurses, and of obtaining governmental support for schools of nursing.

First year qualifying examinations have been approved by the senate of the University of Saskatchewan and are to go into effect on January 1, 1947.

Uniform policies for all schools of nursing in Saskatchewan covering fees, uniforms, monthly allowances, and length of preliminary period have been agreed upon. The preliminary period will be extended to six months for students entering a school of nursing on or after January 1, 1947. Under these regulations it has been agreed that student nurses in Saskatchewan will be exempt from the Minimum Wage Act.

The provincial government has given a grant for 1946-47 to support the development of the Nurse Placement Service in Saskatchewan.

Parcels for Great Britain and War-Devastated Countries

The International Council of Nurses has given out many names of nurses in war-devastated countries to whom Canadian and American nurses sent individual parcels of food and clothing. Letters of thanks and appreciation have been received by the senders in many cases. However, there are many nurses who have not received such letters and who are, naturally, disappointed. In some cases either the parcel or the letter of thanks may have been lost, or the sender's name may have become illegible or have been torn off the parcel by the recipient in the first excitement over the gift. It is, therefore, suggested that all senders of parcels put a card with their name and address, IN PRINT, inside each parcel and that they follow up the parcel with a letter announcing the parcel and asking for an acknowledgement. It could also be stated that no further parcels would be

sent if no acknowledgement was received. It is also extremely important to use strong corrugated cardboard boxes *and* wrapping paper, since many parcels get lost because they are crushed or otherwise damaged and the paper torn off.

It is hoped that unfortunate experiences will not discourage nurses in the more fortunate countries from sending parcels to their suffering colleagues who always appreciate any useable gift of food or clothing and who feel deeply grateful for them. We also suggest that the names of nurses who do not acknowledge parcels be sent back to I.C.N. headquarters or to the C.N.A. in order that steps may be taken to contact the nurse in question.

Finally, we would like to remind senders of parcels that to most European countries packages still take an average of three months and that letters, if they are not sent air mail, take almost six weeks.

Notes du Secrétariat de l'A.I.C

CONSEIL INTERNATIONAL DES INFIRMIERES

Pour la première fois depuis 1937, il y aura réunion du conseil international des infirmières. Ce congrès, qui normalement a lieu tous les quatre ans, aura lieu à Atlantic City, N.J., du 11 au 16 mai 1947. Il y aura, au préalable, réunion d'affaire à Washington des membres du bureau, du 5 au 6 mai, et des membres du grand conseil de C.I.I. du 7 au 9 mai: à cette assemblée il y aura élection des dignitaires du bureau des directeurs. Le bureau des directeurs se compose d'une présidente, de trois vice-présidentes et d'une trésorière, élues par le grand conseil qui se réunit tous les quatre ans. Le grand conseil se compose des membres du bureau des directeurs, des présidentes des associations nationales, de quatre déléguées pour chaque pays, et d'une déléguée choisie parmi les membres de l'association nationale.

A l'assemblée du grand conseil à Washington, il se peut que le secrétaire de chaque association nationale soit invitée; cette suggestion a été faite lors de l'assemblée du bureau des directeurs, qui eut lieu à Londres en septembre 1946. Les rapports des présidentes, secrétaires, et trésorières de tous les comités devront être présentées lors de cette réunion. Les résolutions soumises par les associations nationales devront être inscrites sur l'agenda. Une fois ces résolutions approuvées par le bureau des directeurs, elles seront soumises au grand conseil pour adoption.

Lors de la réunion du grand conseil, l'on exposera la politique du C.I.I. et le travail à faire durant les quatre années à venir. L'on demandera à toutes les associations nationales de présenter leurs rapports avant le 1er janvier 1947. Ces rapports doivent être traduits et imprimés avant d'être présentés aux déléguées. L'ouverture du congrès international se fera dimanche, le 11 mai, et débutera par un service religieux qui aura lieu dans une église catholique et dans une église protestante. Les inscriptions seront reçues durant le reste de la journée. Lundi, le 12 mai, il y aura une assemblée générale. Les détails du programme seront donnés par la "American Nurses' Association" qui reçoit le congrès international. Samedi, le 17 mai, le nouveau bureau des directeurs aura sa première réunion.

L'Association des Infirmières de Suède a invité le C.I.I. à tenir le prochain congrès (après celui de 1947) à Stockholm.

Toutes les infirmières enregistrées sont cordialement invitées à assister au congrès international. La carte d'enregistrement, ou la preuve que vous êtes membre d'une association nationale, sera le seul document demandé pour votre inscription comme membre du congrès international et celà vous donnera droit de prendre part à toutes les séances et fonctions.

Les infirmières étudiantes sont aussi invitées mais on doit en limiter le nombre à une représentante par école. En plus des élèves infirmières, d'autres personnes seront reçues comme invités spéciaux, des médecins, des personnes de profession, ou des personnes particulièrement intéressées à la profession d'infirmière.

AMERICAN NURSES' ASSOCIATION

Il nous est impossible de donner un rapport de toutes les assemblées et conférences qui ont eu lieu lors du congrès de la "American Nurses' Association" du 23 au 27 septembre 1946; nous nous contentrons de signaler les faits principaux.

La décision prise par les déléguées d'autoriser les associations de chaque état et les associations divisionnaires d'être les agents mandataires exclusifs pour les infirmières aura une grande répercussion.

La structure de la nouvelle organisation du nursing fut l'objet d'un rapport des plus intéressants et fut marquée sur l'agenda comme l'un des sujets les plus importants. (Voir l'*American Journal of Nursing*, oct. et nov. 1946.). Chaque infirmière est priée d'étudier avec soin ce programme puisque les deux suggestions qui y sont faites ont une grande portée et auront une non moins grande répercussion sur la profession. Dans les relations entre employeurs et employées il y a eu beaucoup de discussion concernant la ligne de conduite suivie à l'égard des infirmières. Il est non seulement nécessaire d'avoir par écrit l'échelle des salaires payés par l'institution ou l'organisation, mais en plus les heures et conditions de travail, etc. En plus l'on discuta de la nécessité d'analyser le travail, les obligations que chaque position comporte, et les qualifications requises de la part de l'infirmière désirant obtenir cette position; l'on discuta aussi des années de service et du travail sortant de l'ordinaire.

Le programme suivant fut tracé pour les deux années à suivre:

1. Amélioration dans les heures et les conditions de travail pour les infirmières afin qu'elles puissent avoir une vie personnelle aussi bien que professionnelle normale; pour atteindre ce but que chacune travaille: (a) à faire accepter plus généralement la semaine de 40 heures, sans diminution de salaire, applicant aussi le principe de la journée de 8 heures déjà adopté par la "American Nurses' Association" en 1934; (b) à ce que le salaire minimum soit suffisant pour attirer et garder les bonnes infirmières tout en leur permettant de vivre aussi bien que les membres des autres professions.

2. A ce que l'on prenne les mesures nécessaires pour assurer les meilleurs soins, pour tous, en cas de maladie et qu'en plus un programme de santé, bien défini, soit établi pour tous les milieux.

3. A ce que les infirmières prennent une plus grande part dans l'organisation et l'administration des services de santé, des hôpitaux et autres services du même genre.

4. A ce que l'on demande de plus en plus l'intervention d'association professionnelle d'infirmières comme porte-voix des infirmières pour tout ce qui concerne leurs emplois et la sauvegarde de leurs intérêts. Ce service se développera en raison des succès obtenus par les associations professionnelles comme agent mandataire et dans les contrats collectifs.

Voici le texte de la recommendation faite par le comité des aviseurs aux déléguées de l'A.N.A. (sept. 22 1946):

"La 'American Nurses' Association' croit que dans plusieurs états les associations d'infirmières de l'état et des associations divisionnaires ont qualité pour agir, et doivent agir, comme agent exclusif chargé de représenter leurs membres dans le domaine important des questions économiques et dans les contrats collectifs. L'association commenta les progrès déjà réalisés et recommenda à toutes les associations d'états et de districts de pousser immédiatement et avec vigueur ce mouvement."

5. Que l'on enlève toutes entraves empêchant de donner à un groupe minoritaire d'une race un développement professionnel complet et d'accès à toutes les positions.

6. Que l'on emploie des aides-malades bien préparées et d'autres aides; que toutes obtiennent une licence de l'état afin que le public aussi bien qu'elles-mêmes soient protégés.

7. Que les bureaux de placement soient continuellement améliorés afin d'assurer à l'infirmière un travail plus stable, plus satisfaisant, et afin de faciliter une meilleure distribution du service d'infirmières.

8. Afin que le nursing soit en marge des progrès accomplis par la médecine et les autres sciences, que le niveau de l'instruction soit maintenu, et que toutes les ressources éducationnelles facilitant la formation de l'infirmière soient développées. Le développement de ces ressources éducationnelles peut nécessiter l'aide financier du gouvernement fédéral, des contributions de fondations et d'autres sociétés philanthropiques.

Résumé: Si la profession d'infirmière est prête à prendre une ferme décision concernant les heures de travail, les salaires, le progrès économique, étendre le nursing tout en maintenant les standards et à considérer la réorganisation de la structure professionnelle, la "American Nurses' Association" aura écrit durant cette convention une page de l'histoire de la profession.

Les Associations Provinciales, A.I.C.

Alberta: L'on est à reviser la loi des infirmières de l'Alberta. Un comité d'éducation a été nommé; Mlle H. Penhale en est la convocatrice. Les sujets suivants ont été étudiés par ce comité:

(a) La possibilité d'augmenter les affiliations pour les élèves des écoles d'Alberta, afin qu'elles aient de l'expérience en tuberculose et en psychiatrie et aussi dans les petits hôpitaux ruraux préalablement choisis et approuvés.

(b) La possibilité de la création d'une école centrale d'infirmières, afin d'augmenter le nombre d'infirmières diplômées chaque année en Alberta et aussi afin de faciliter et améliorer la formation des élèves infirmières.

(c) L'organisation de cours de courte durée sur la technique des examens et autres questions s'y rapportant. Un mémoire sur la loi des Assurances de Santé de l'Alberta fut préparé et envoyé au Ministère de la Santé. Les institutrices sont à reviser le programme minimum des écoles d'infirmières d'Alberta.

Afin de venir en aide aux bureaux de placement, on leur a attribué $1.00 de la contribution annuelle de $5.00.

Colombie Britannique: Les cinq plus grandes écoles d'infirmières ont reçu toutes les élèves qu'elles pouvaient loger: deux grandes écoles ont reçu plus de demandes qu'elles pouvaient en accepter. L'on compte 439 vacances dans les écoles d'infirmières hygiénistes, dans les hôpitaux et les institutions.

Plus de trente employeurs ont prévenu le bureau de placement des infirmières que toutes ou presque toutes les recommendations qui leur ont été faites ont été exécutées ou sont actuellement sous considération.

Une série de bulletins sur les relations entre employées et employeurs, préparés par un sous-comité du comité des relations ouvrières, seront distribués aux infirmières dans les hôpitaux, institutions, cliniques, aux infirmières visiteuses, et aux infirmières aux services d'hygiène et de santé.

Un comité conjoint sur l'organisation du nursing fut formé en août: il est composé de représentants du ministère de l'Education, de la Santé et du Bien-Etre social, de la Fédération des Oeuvres de Charité, et de l'Association des G.M.E. de la Colombie Britannique. Un sous-comité s'occupera de préparer un plan dans le but d'analyser le travail à l'hôpital et les programmes d'étude. Le président a choisi, parmi le personnel des hôpitaux, un comité chargé de faire rapport sur les personnes n'ayant aucune formation professionnelle travaillant dans les hôpitaux; quel travail font actuellement ces personnes et quel autre travail pourraient-elles faire pour diminuer le travail de l'infirmière.

Manitoba: Deux infirmières furent nommées par le ministre de la Santé et du Bien-Etre social sur un comité chargé d'étudier: "Le cours d'infirmière et comment assurer aux hôpitaux ruraux un personnel convenable."

Les institutrices se sont réunies en juin à l'Université du Manitoba. Il y eut discussion sur le programme d'étude, sa valeur à la lumière des résultats obtenus aux examens. L'on revisa le programme de la première année du cours. Le comité conjoint du nursing en tuberculose fit rapport que les infirmières enregistrées ne veulent pas faire du service chez les tuberculeux.

Nouveau-Brunswick: L'on fait actuellement l'étude d'un projet de loi qui accorderait une licence aux aides-malades. La contribution annuelle pour l'enregistrement est maintenant de $5.00.

Nouvelle-Ecosse: L'Association des Infirmières de la Nouvelle-Ecosse a autorisé son comité de législation à étudier les lois et règlements de l'association dans le but d'une revision. A l'assemblée annuelle il fut proposé que des débats sur la Santé et le Bien-Etre soient organisés dans le but de stimuler l'intérêt et d'aider aussi à la solution de quelques problèmes du nursing.

Ile du Prince Edouard: L'on travaille à la revision des lois et règlements.

Québec: Notre plus grande préoccupation actuellement est la préparation des règlements conformément aux exigences de la nouvelle loi. Il y aura aussi des changements dans l'administration.

Le comité des aides ou auxiliaires s'est réuni trois fois; comme résultat un comité d'étude fut nommé dont le but est de soumettre un projet de licence, projet qui sera étudié par un groupe plus important. Le rôle de l'aide, etc., l'échelle des salaires dans les hôpitaux furent des sujets étudiés par trois conseils d'hôpitaux de la province. La cotisation a été augmentée à $6.00.

L'intérêt montré soudainement par les syndicats ouvriers envers les infirmières est dû au fait qu'à partir du 31 décembre 1946, infirmières seront légalement reconnues comme infirmières professionnelles.

Saskatchewan: L'Association des Infirmières de Saskatchewan par son comité conjoint étudie les moyens à prendre pour obtenir des infirmières enregistrées, qu'elles ne fassent que du travail professionnel, pour avoir un plus grand nombre d'infirmières professionnelles, pour obtenir des subsides du gouvernement pour les écoles d'infirmières.

Les examens d'enregistrement de la première année ont été approuvés par le conseil des études de l'Université de Saskatchewan et seront en vigueur à partir en 1947.

Les écoles d'infirmières de la Saskatchewan se sont entendues pour qu'il y ait uniformité de droit d'entrée, dans la rémunération mensuelle, l'uniforme, la durée du cours préliminaire. Le cours préliminaire sera de six mois pour les élèves admises à une école le ou après le 1er janvier 1947.

Les élèves étudiantes, à la suite de cette entente, ne seront pas soumises à la loi du salaire minimum.

Le gouvernement de la Saskatchewan a donné un octroi pour aider au développement des bureaux de placement des infirmières de la Saskatchewan.

Annual Meeting in New Brunswick

The thirtieth annual convention of the New Brunswick Association of Registered Nurses was held in Trinity Church Vestry, St. Stephen, on September 25 and 26, 1946. Following the invocation by Rev. A. R. Smith, Rector of Trinity Church, a gracious welcome was extended to the guests by the mayor of St. Stephen. Messages of greeting were read by the secretary.

With a registration of 135, we felt we had a good representation, considering the crowded conditions of the hospitals. There were members from all branches — superintendents of nurses, instructors, head nurses, private duty and public health, and among these was a goodly number of the younger nurses who showed a keen interest in the proceedings which bodes well for the future of the association.

The president, Miss M. Myers, presided at all sessions. In her presidential address she reminded the members of the need to study seriously what is going on in nursing today and to ask themselves why certain things come about and whether we, as individuals, have any responsibility in the matter whatsoever. Shortage of nurses is, of course, uppermost in the minds of everyone as it is evident in all types of nursing and the question is asked: Are the members doing their best to relieve this acute shortage by fullest co-operation with institutions and individuals requiring nursing service?

This year all reports were compiled in pamphlet form previous to the meeting and each member received a copy on registration. The executive secretary covered the work of the association for the past year, as carried on in the provincial office. Hospital expansion is being carried out as rapidly as possible in almost every locality. This included hospitals with training schools, small private hospitals, as well as outpost hospitals sponsored by the Red Cross. The same difficulty confronts us there in finding nurses to staff these hospitals, but by some means or other the work is being done, perhaps not quite as well as we would like, but at least the patients are being cared for. In view of the acute shortage of nurses temporary, or courtesy, registration is being granted for another year to nurses remaining in the province less than a year, and to those not meeting the requirements of our registration act.

Legislation: The proposed Constitution and By-laws of the Canadian Nurses' Association were presented by the convener of Legislation, Miss H. Bartsch, and discussed in detail. A resolution for the acceptance of the Constitution and By-laws, including amendments submitted from the biennial convention, was adopted.

Chapter reports showed a busy year, each chapter making their meetings as interesting as possible by having speakers on different subjects.

Dr. J. A. Melanson, Deputy Minister of

Health, gave an interesting and stimulating address on the present and future program of his department. The set-up is a beginning of widespread plans for the health of the public. He touched on the increased number of beds available for tuberculosis patients; the poliomyelitis clinic in Fredericton; the cancer clinic in Saint John, and the prospect of more public health doctors and nurses in the field.

Following this a report on the proposed licensing of the subsidiary nurse was presented by the convener, Miss Hunter. A school for trained attendants was opened in Moncton in July under the sponsorship of the C.V.T. It is hoped that the licensing bill, as submitted under the Department of Health, will be approved by the time these workers are ready for placement. A long discussion took place regarding this.

Special events of a delightful character were: A tea given by the St. Stephen Chapter at the end of the first day's sessions. In the evening a banquet was held at which Mr. Stuart Trueman, associate editor of the *Telegraph-Journal*, Saint John, was guest speaker. He gave a very interesting talk on the work of the press and its responsibility in maintaining an informed public. On the final day of the meeting we were again entertained at luncheon by the St. Stephen Chapter when the nurses had an opportunity to meet informally.

The three sections held their meetings concurrently on the morning of the second day.

The *Public Health Section* had a very active year; a new sub-section of the provincial section was formed during the year. This sub-section is so near the Nova Scotia border that nurses from the two provinces are able to meet together which makes it a most interesting set-up.

Hospital and School of Nursing Section: A committee was appointed to continue the preparation of our minimum curriculum for use in all the schools of the province with the object of having first-year qualifying examinations. The N.B.A.R.N. went on record as supporting the resolution regarding the educational standard for schools of nursing as submitted by the Canadian Nurses' Association. A letter is to be sent to each superintendent of nurses in the province advising her of this resolution.

From the *General Nursing Section* report came many matters for discussion; it was urged by the convener that general duty nurses be invited to nurses' staff meetings, to bring about better co-operation between the two bodies. Again the matter of nurses wearing uniforms on the streets was discussed from several angles. The association went on record as disapproving of the wearing of uniforms on the street except on official occasions. The general nursing fees were increased to: 8-hour duty, $5; 12-hour duty, $6; 20-hour duty, $7.

The Canadian Nurse: Letters have been sent to nurses whose subscriptions have lapsed and contacts made with nurses who have never subscribed to the *Journal.* One hundred and seventy-five new subscriptions were received during the year.

Nurse Placement Service: This service has now been in operation for two years and is carried on at the provincial office. The shortage of nurses makes it difficult to function as we would like, but it is felt it will be much more useful in the future. About 25 per cent of the requests for nurses in institutions and public health have been met.

A brief was presented by a committee from the Maritime Hospital Association in an effort to secure nursing service in tuberculosis sanatoria. It was recommended that publicity be given through the press and radio to dispel the fear that is apparent in the minds of parents as well as candidates concerning tuberculosis nursing. Two other recommendations were: Since the services of trained attendants has proved of great value, That serious consideration be given to the continuance of the school for trained attendants in Moncton; and, That an attempt be made to secure affiliation for schools of nursing with sanatoria. A committee was appointed to study these questions and contact schools of nursing to see what could be done regarding affiliation.

Concerning Resolution No. 1, as submitted by the Canadian Nurses' Association:

That, due to a steadily growing and urgent demand for more nursing service, it was resolved that the Canadian Nurses' Association recommend to the Provincial Registered Nurses' Associations that they immediately form committees representative of all branches of nursing; that these committees proceed immediately to take whatever steps may be necessary to train a sufficient number of nurse-aides and that, in order to protect both the community and the workers, continued efforts be made to obtain licensing regulations for these auxiliary workers;

that since this necessary expansion in the supply of nurses is not solely the responsibility of hospitals, and since present educational facilities are not adequate to produce a sufficient quantity of the best quality of graduate nurses, efforts be made to secure Governmental support for schools of nursing.

This resolution was discusssed and the following motion carried:

That the incoming executive be requested to study said resolution and be given power to formulate a special committee as recommended and, if deemed advisable, approach Governmental bodies concerned for financial assistance for schools of nursing.

The following slate of officers was presented and elected for 1946-48:

President, Marion Myers; first vice-president, Reta Follis; second vice-president, Hilda Bartsch; honorary secretary, B. M. Hadrill. Section chairmen: Hospital and School of Nursing, Sister Rosarie; General Nursing, Mrs. B. Nash Smith; Public Health, Lois Smith; Legislation Committee, Isabel Lane; *The Canadian Nurse*, Edna Henderson; councillors, Margaret Murdoch, Mabel McMullen, A. J. MacMaster, Sister Anne de Parede, M. E. Hunter.

An invitation was accepted from the Saint John Chapter to meet in Saint John in 1947.

ALMA F. LAW
Secretary-Registrar

Annual Meeting in Ontario

The twenty-first annual meeting of the Registered Nurses Association of Ontario, held in Toronto at the Royal York Hotel on October 29, 30, 31, 1946, was opened by the president, Miss Jean I. Masten. The registration of 496, including 53 student nurses, was larger than at first anticipated as the Ontario Hospital Association convention had been held in Toronto the previous week. The president extended a welcome to all members, and especially to Miss Winnifred Cooke, assistant secretary, C.N.A. The association was very pleased that it was possible for Miss Cooke to attend the meeting and appreciated her assistance in giving further information in connection with some of the questions under discussion. The association was pleased to have as their guest, Miss Helen McArthur, chairman, Public Health Section, C.N.A. It was indeed fortunate for Ontario that Miss Ethel Johns was residing in Toronto and was so willing to assist on the program.

A folio of the reports to be presented was prepared for distribution to all who registered. The important questions discussed at the opening session on Tuesday afternoon included the amendments to the C.N.A. Constitution and By-laws, which were forwarded to the provincial associations following the biennial meeting, with the understanding that each association would have the right to express its approval or disapproval of the adoption of the new Constitution and By-laws before November 15, 1946. The members attending the annual meeting had the privilege of voting by ballot during the hours of meeting. The result of the votes cast showed that the decision was against the adoption of the new Constitution and By-laws.

The program included two panel discussions. One entitled "Population Trends in the Community and their Effect on the Future of Nursing" was conducted under the chairmanship of Miss Edna L. Moore, assisted by Prof. V. W. Bladen, M.A., F.R.Sc., Department of Political Economy, University of Toronto, and director, Institute of Industrial Relations; Mr. H. E. Elborn, principal, Toronto Normal School; Miss E. Kathleen Russell, director, School of Nursing, University of Toronto; and Miss Ethel Johns, formerly editor of *The Canadian Nurse*. The second panel discussion on "The Changing Responsibilities of the Nurse with Respect to Modern Methods of Treatment and Rehabilitation" was conducted under the chairmanship of Miss N. D. Fidler and assisted by Dr. Roscoe R. Graham, F.R.C.S. (c), assistant professor of surgery, University of Toronto; Miss Nan Landon, private duty nurse, Ottawa; Miss Hilda Coates, instructor, Wellesley Hospital, Toronto; and Miss Jean Leask, assistant superintendent, Toronto Branch, Victorian Order of Nurses. The nurses were keenly interested in these panel discussions and the attendance at each was approximately 750.

The annual dinner was held on Wednesday, October 30, when Miss Anna Schwarzenberg, executive secretary, International Council of Nurses, spoke on "Today and Tomorrow in International Nursing." The address given by Miss Schwarzenberg on the nursing situation in England and European countries as observed during her recent visits, as well as the announcement regarding the International Congress of Nurses to be held in Atlantic City in May, 1947, was listened to with keen interest by the 636 persons present.

The business meetings of the Hospital and School of Nursing and the Public Health Sections were held concurrently on Wednesday afternoon. These meetings were followed by a general meeting when Miss Edith Young, as chairman, conducted a round table discussion on "The Independent School of Nursing," Miss N. D. Fidler, professor, University of Toronto School of Nursing; "Personnel Policies in the Field of Nursing," Miss Gladys Sharpe, director of Nursing Education, McMaster University, Hamilton.

The business meeting of the General Nursing Section was held at 5 p.m. to enable private duty nurses who were on duty during the day to attend. This departure from the usual procedure proved so successful that the section decided to make the same plans for 1947.

The 1946 annual meeting was held in October due to the problem of hotel accommodation. However, it was the decision of the members that we return to the former policy of holding the annual meeting in the spring. The nurses of Hamilton extended an invitation which was unanimously accepted and arrangements have been made to hold the meeting at the Royal Connaught Hotel on April 23, 24, and 25, 1947.

MATILDA E. FITZGERALD
Secretary-Treasurer

Meeting Health Needs of School Children

Public health and school departments need to work together so that the health program of the schools is co-ordinated with that of the community as a whole.

The health needs of school-age children are stated to be: (1) A safe, sanitary, healthful school environment. (2) Protection from infections and conditions which interfere with proper growth and development. (3) An opportunity to realize their potentialities of growth and development. (4) To learn how to live healthfully. (5) Teachers who are equipped by training, temperament, and health not only to give specific instruction but also to help them to mature emotionally.

Data are presented to show that these health needs are not being met. An efficient, effective health program for all children of a community will result only when: (1) The public departments of health and of education, as well as specialized personnel within each department, agree to the principle of co-ordination of health programs for school children, including the health program of the community and the health aspects of school programs. (2) Each agency and profession respects the contribution of the others. (3) The agencies agree to an administrative plan which will promote the most efficient and co-operative direction of the several phases of the program and the supervision of the several types of professional workers. (4) The professional workers of each agency are permitted to perform services in their professional fields for the best interest of all children. (5) Sufficient funds become available to carry out the program.

— *California's Health*

Worry thrives on concealment of its cause. It usually happens that when the cause is discussed frankly with some trusted person, the load of worry grows much lighter, if it does not disappear altogether.

Interesting People

The honor and responsibilities of being president of the Ontario Hospital Association have been conferred upon **Priscilla Campbell,** the second time in the history of the association that this position has been held by a woman, a nurse.

Miss Campbell has a sound background of administrative experience to fit her for this important role. She graduated from Royal Victoria Hospital, Barrie, Ont., in 1916. Her qualities of leadership were immediately manifest and she served successively as night supervisor, operating-room supervisor, and assistant superintendent of her home school of nursing, going in 1920 to Brockville General Hospital as superintendent. In 1922, Miss Campbell was appointed superintendent of the Public General Hospital, Chatham, Ont., where today she occupies the position of administrator.

Broadening her background for administrative work, Miss Campbell went to London, Eng., and had practical experience at St. Thomas, Guy's, St. Bartholomew's, and Bethlehem Royal Hospitals. She is a member of the American College of Hospital Administrators and Canadian representative on the Council of Public Relations of the American Hospital Association. She has been a member of the Board of Directors of the Ontario Hospital Association since 1923. She is on the Council of Nursing Education for Ontario, and past president of District 1 of the R.N.A.O. She is a member of the Women's Canadian Club, the Business and Professional Women's Club, and the Twentieth Century Club.

Added to her fine record of achievement and her knowledge of hospital management, Miss Campbell has our good wishes for a very successful term of office.

PRISCILLA CAMPBELL

Of interest to many Canadian nurses will be the news that **Mary P. Connolly** was the recipient of the 1946 Elisabeth S. Prentiss National Award in Health Education. Miss Connolly is probably best known to health educators through her work as Director of Health Education, Department of Health, City of Detroit. She is a fellow of the American Public Health Association. She served as secretary of the Health Education Section of the A.P.H.A. for several years and became its chairman in 1939.

Miss Connolly, who holds her M.S degree from the University of Detroit, took her basic training in nursing at St. Agnes Hospital, Philadelphia. From 1911 to 1914 she was director of nursing education, St. Joseph Hospital, Reading, Penna. During World War I she instructed with the American Red Cross in Philadelphia from 1915 to 1918. In 1918 she joined the staff of the Detroit Department of Health. She was

Cleveland Health Museum

MARY P. CONNOLLY

director of health education, until 1943, for twenty-five years. Since 1942 she has been lecturer and director of health education, School of Public Health, University of Michigan. She is a member of Delta Omega, the honor society in public health.

The award was established in 1943 by Cleveland Health Museum for an individual or persons working in co-operation who have made outstanding contributions in the field of health education. The award is symbolized by a plaque and a citation which follows: "The Elisabeth S. Prentiss National Award in Health Education for 1946 is presented to Mary P. Connolly, M.S., R.N., Down-to-Earth Health Educator, Detroit Department of Health, 1918-43; University of Michigan, School of Public Health, 1943; by the Board of Trustees, Cleveland Health Museum on November 13, 1946."

SISTER DELIA CLERMONT

The capable, national chairman of the Committee on Institutional Nursing during this biennium is **Reverend Sister Delia Clermont.** Of French parentage, Sister Clermont was born in Saskatchewan, receiving her early schooling in Weyburn, She received her first class teacher's certificate from the Regina Normal School in 1926. In 1930, she commenced her training in the school of nursing of St. Boniface Hospital, Man. She served as head nurse on a medical ward before going to St. Louis University where she secured her degree of Bachelor of Science in Nursing Education. Returning to her home school, Sister Clermont was successively instructor, assistant superintendent and superintendent of nurses. Since 1943, she has been educational director of the school of nursing.

Sister Clermont is second vice-president of the Manitoba Association of Registered Nurses, and served as first vice-chairman of the Hospital and School of Nursing Section, C.N.A.

Ella Mae Howard has been appointed to the staff of the school of nursing of the University of Toronto, to administer and teach in the courses in clinical supervision.

Miss Howard was born in Ontario and received her early education in Alberta. After graduating from Calgary Normal School she taught in the public schools of Alberta for several years. In 1937 she graduated from the school of nursing of the Royal Alexandra Hospital, Edmonton, and in 1939 obtained her certificate in teaching and supervision from the McGill School for Graduate Nurses.

Since 1940 Miss Howard has been instructor at the Nicholls Hospital, Peterborough, Ont., assistant superintendent of nurses at the Regina General Hospital, director of nursing at Saskatoon City Hospital, and director of publicity and recruitment for the Alberta Association of Registered Nurses. In 1946 Miss Howard obtained her B.S.N.

ELLA M. HOWARD

THEODORA BERTRAND

degree from Western Reserve University, Cleveland.

Miss Howard's personality, preparation and breadth of experience make her a most valuable addition to the Toronto school.

Theodora R. Bertrand est une infirmière diplômée de l'Hôpital Notre-Dame. Après quelques années de service privé et de service pour la Metropolitan, elle accepta le poste de directrice de l'Hôpital Normand et Cross, aujourd'hui Hôpital privé de Trois-Rivières, et de l'école d'infirmières qui fut attachée à cet hôpital jusqu'en 1934. Mlle Bertrand fut une élève du premier cours post-scolaire donné par l'Université de Montréal en 1924 et montra toujours un grand intérêt envers la profession.

La carrière de Mlle Bertrand porte la marque du plus grand dévouement. Ses anciennes élèves trouvèrent toujours en elle une conseillère dévouée et éclairée. Lors d'une fête intime, les médecins de cette institution, les anciennes élèves, et quelques amis se réunirent pour lui offrir un hommage de reconnaissance bien mérité.

Elizabeth McKee has retired from the post of night supervisor at the Hamilton General Hospital, Ont., the duties of which she has discharged with skill and unvarying devotion for the past twenty years. This much-loved nurse had hoped to retire some years ago but remained at her work during the urgent period of the war.

Miss McKee is one of a family of six daughters, four of whom chose nursing as their life work. She began her training at Mount Sinai Hospital. At the end of her first year there, she returned home to care for her mother for several years. She resumed her training in the Orthopedic Hospital with affiliation at the Toronto East General Hospital. She had a post-graduate course at the New York Lying-In Hospital.

Among her associates Miss McKee is noted for her quiet dignity, kindness, and efficiency. Our good wishes follow her in her release from active duty.

Historical Sketch of Medicine

A. GAUM, M.D.

MEDICAL RESEARCH has been so vast and fertile and its relations with other sciences so numerous, that the presentation, even of the principal discoveries and concepts of the time, looms as an almost impossible task. As a result, this discussion can only be superficial in nature. In the second half of the nineteenth century, and in the beginning of the twentieth, the discovery of the telephone, automobile, wireless, television, the radio, and the aeroplane have all played an important part in influencing medicine. Patients are now brought quickly and easily across long distances to medical centres—unthought of in previous generations. It is difficult to exaggerate the effects and progress that such social changes have made on medicine.

During this period, and perhaps as the result of the new orientation of medicine, we see a great tendency to specialization. The new task of the physician, still constantly increasing, obliges him to use long and complicated laboratory studies, and requires of him special knowledge in various branches, specialized technique, skill, and the almost impossible labor of keeping up with the flood of new scientific discoveries. It has become necessary for some physicians to occupy themselves exclusively with laboratory work. On the other hand, the steady progress in all the specialties, requiring intensive study and continued practice, has necessitated that many physicians devote themselves exclusively to a single specialty.

The general physician, practising all branches of medicine, has become more rare during this period, and even those of us who indulge in general practice frequently summon the aid of specialists. However, it will be an unfortunate day when the family physician disappears from the medical horizon. No matter how the complexities of medicine develop, it would seem there would always be a prime need for the general physician as well as for specialized medical knowledge, even though an increased part of his task may be to direct the patients towards a proper specialist.

Never before has medicine penetrated to such an extent into the social life of the time. This century has seen the development of the supervision of the child, beginning on the day of his birth and continuing through his whole life. His diet is controlled, his physical and mental hygiene cared for, and his mental attitudes tested psychologically. The physician now enters the factories, controls the installation of safety devices, and gives care and treatment for industrial diseases. To this period also belongs the development of public health statistics.

In the latest conquests of human intelligence, medicine has had to map out proper regulations for the individual who is to operate in high altitudes. These bonds of medical discipline with other sciences constitute an important factor in increasing the penetration of medical knowledge. The enormous influence of the press is a further contributing factor. Another circumstance which has influenced medicine of modern times is the development of industry and a better organization of the working classes. This then truly is the renaissance of medicine.

In this century, biology was established on a firm basis. The study of the structure of the nucleus begun by Purkinje led to the discovery of its granules and nuclear membrane. In 1846, the word "protoplasm" was first given to the contents of the cell by the botanist, Hugo Von Mohl. These discoveries were important because they lead later to chemotherapy, beginning with Ehrlich's discovery of the various dyes and the cure for syphilis. Then followed studies on fertilization and heredity, so clearly authenticated by Mendel in his Mendelian Law. While the rapid development of biological science was bringing light to many obscure fields, physics and chemistry were also progressing in ways which had valuable results on medical thought and practice. For example, Emil Fisher's work in 1906 on the chemistry of protein, the study of carbohydrates, and the discovery of the electrons—from this grew the important study of radio energy and radio-active substances. In 1895, Roentgen discovered the rays which lead to our modern x-ray. In 1896, Pierre and Marie Curie isolated from tons of pitchblende, a radio-active substance which was eventually to become known as radium.

Deficiency diseases had been known for some time without actual knowledge of what substances were deficient. Scurvy ravaged the sailors of Vasco de Gama and Cartier, who learned from the Indians how to cure them with the juice from the Ameda tree. Then there were the English "Lime Juicers" who introduced the fruit, lime, against scurvy. Takaki had greatly decreased the ravages of beriberi in the Japanese Navy by adding variety to the polished rice which was later shown to be deficient in vitamin B_1. It was left to Eikjman to discover that the husks of the rice contained the important substance vitamin B_1. In 1925, Holmes showed that rats deprived of vitamin A acquired night blindness and since then we have isolated practically every known vitamin and shown their importance.

With the perfection of new staining methods and improvement in the miscroscope, histologic and cystologic knowledge were greatly extended and thus anatomy was established on a firm basis. In this era, such names as Cajal and Golgi have left their stamp on the studies of the nervous system. Then William Bowman discovered in the kidney the glomerular capsule. In this period, physiology underwent a marvellous development. The true foundation of anatomy having been made, science now turned to the study of body function in all its branches and with the aid of physics and chemistry discovery followed discovery. In the physiology of the blood, Cohnheim established the ameboid movement of the leukocytes in their passage through the blood vessels in inflammation. In 1892, when Metchnikoff discovered phagocytosis, the physiology of the circulation attained its mark.

Studies of the internal secretions have assumed high importance in recent times. The active principal of the adrenal gland, adrenalin, was discovered by Bell. Cortin, the active principal of the adrenal cortex, is a more recent discovery. In 1921, Banting and Best isolated insulin from the pancreas, which has done so much to prolong the life of diabetics. At present, work is being done on the pituitary gland, and it is felt that this also plays an important part in the diabetic process. Studies on exophthalmic goiter and myxedema have led to the discovery of Thiouracil and thyroid extract. The insignificant parathyroids were recognized in 1891 as being most important for maintaining life and that the disease of osteitis fibrosa cystica, due to excessive parathyroid secretion, could be relieved by the removal of the parathyroid tumor.

In the physiology of digestion, important work was done by Ivan Petrovich Paplov. Pathologic anatomy also came into its own in the second half of the nineteenth century, receiving an impetus from such men as Rokatinski and Virchow. Tuberculosis was first recognized in 1898 by Koch; malaria and its etiology was established by Sir Ronald Ross. Research in the histogenesis of the blood cells and the function of bone marrow gave the necessary foundation for the knowledge of pathology of blood-forming organs; thus began a new era in the pathology of the blood.

A tremendous advance has been made in microscopic technique during the past fifty years through the methods of fixation and staining. This opened new fields in the special pathology of blood, bones, and muscles. Knowledge of the anatomy of the genital organs progressed, especially in relation to lesions of the testicles and ovaries. We now recognize benign tumors as sources of bleeding. Cysts of the ovaries were made familiar by the classical operation of McDowell who removed the first ovarian tumor. The studies of malignant tumors became classified and attempts to advance with the cancer problem by experimental research are now being made throughout the world along many lines. The cause of cancer still awaits a complete answer.

Bacteriology can be credited as being the mother of prophylaxis. Thanks to the brilliant studies of Louis Pasteur, bacteriology came into its own. He differentiated between aerobic and anaerobic bacteriology. Other contributions he made to medical science were his studies on cholera, anthrax, and rabies. Then there was Klebs, who discovered the diphtheria organism, Welch who demonstrated the gas gangrene organism, and Neisser who discovered the gonococcus.

Immunization became a reality in the latter half of the nineteenth century and early half of the twentieth with the treatment of such diseases as diphtheria, typhoid fever, and whooping cough. In 1906, Wassermann gave us his important serological test for syphilis. Landsteiner discovered that human blood could be divided into four or more blood groups which has permitted the extensive use of blood transfusions as a valuable and often a life-saving therapy. We have found that with citrates we have been able to keep blood in solution; that it can be held thus for as long as ten days, and often at the end of that time the plasma could be salvaged and used.

It is only natural, with the advent of pathology, physiology, microbiology, and bacteriology, that an improvement in the field of diagnosis should come about. Thus clinical medicine was established and with it such names as Traube who introduced Traube's Space, Leyden who studied poliomyelitis, Kussmaul who studied diabetic coma, also gastric lavage for dilatation of the stomach, which was the forerunner of the Wangensteen apparatus. Eminent among modern physicians was Nauyn, remembered for his studies of gall-stones and diseases of the liver; Curschman, for his studies on bronchial asthma, and Sir William Osler, one of the finest figures of Canadian medicine. His contributions to medicine were his valuable monographs on cancer of the stomach, abdominal tumors, and chorea.

The study and practice of surgery may have been set in motion by the various branches that we have described, but following the fundamental discoveries of anesthesia and asepsis its advance is almost comparable to jet propulsion. With the knowledge of the more secret parts of the body which can be explored without introducing infection, surgical technique has permitted difficult operations undreamed of in earlier days. The clinician, surgeon, pathologist, radiologist, and various specialists not only must collaborate on all obscure cases, but must know enough of the other man's job to make the collaboration intelligent. The need for more precise diagnosis and prognosis, and indications for the proper moment for surgical intervention and subsequent treatment, have been given to us through biopsy and endoscopy which allows us to reach inaccessible body cavities, while x-ray has eliminated many doubts.

Lister's use of powerful antiseptics, with the destructive effects on the tissues, has been universally replaced by asepsis. Instruments, gowns, gloves, etc., are now sterilized by dry heat. Surgery now reaches the most delicate and remote organs, especially in the hands of specialists. Surgery of the brain, lungs, hand transplantations, and plastic surgery have made great progress during this period. Obstetrics also shared in the rapid advance of surgery; the axis-traction forceps considerably extended their field of usefulness and Cesarean sections were more successful. Knowledge of puerperal infection, transmission of syphilis to the fetus, and the cause of toxemia of pregnancy were better understood.

Startling and rapid as this progress has been, it is in no way comparable to the medical progress of the last decade. The training and teaching of nurses and internes has had to be revolutionized to keep up with these developments. It seems only a short while ago that one could walk through the wards and detect the foul smell of pus. Patients with charcot joints, children suffering from osteomyelitis, extension apparatus applied for the correction of tuberculous hips, plaster jackets for Pott's Disease, and numerous patients recovering from mastoidectomies were common. The absence of these cases today is due to the new field of chemotherapy. With the advent of the sulfa drugs and then penicillin, post-operative abscesses have been fewer and recoveries more rapid. Because of the newer concepts of early ambulation we have had fewer post-operative accidents such as embolism, and complications such as phlebitis. Due to the pasteurization of milk there has been less bovine tuberculosis. Because of the prophylactic inoculation of children, there has been less diphtheria and whooping cough, therefore fewer complications necessitating tracheotomy. Because of sulfa drugs and penicillin, infection is controlled and, therefore, less mastoid involvements occur. With the advent of penicillin, the treatment of gonorrhea has become more effective and great hopes are held for its efficiency in combatting syphilis.

Protein therapy has also come into its own, so that today we have the various amino acids which can be given intravenously to maintain the nutrition and metabolism of the patient who is unable to receive foods orally. Nourishment of the patient may be maintained in this manner for many days.

Advances in surgery have been prompted and tested during the world's greatest catastrophy—World War II. Means of combatting shock by blood and plasma have proven effective. Anesthesia has reached high levels with such drugs as Penthol Sodium, Cyclopropane and spinal anesthesia. New materials such as ligatures of nylon or cotton replace catgut; vitallium and tantalum have been used effectively for skull defects, and for creating artificial ducts in gallbladder surgery and arterial anastomosis. Heparin and Dicoumarol have played their part in thrombosis, phlebothrombosis, and embolism, and we have learned to recognize their use at the proper time. Likewise, bronchoscopy has played its part in treating post-operative atelectasis. In fracture work, the revival of internal fixation by plates, screws, and wires is largely the result of increased use of sulfonamides and penicillin.

One could write voluminously about medicine and its numerous striking discoveries in brain surgery, gastric surgery, thoracic surgery, etc., but suffice to say that with the new electronics and atomic energies and other scientific miracles, if one could peer into the future one would marvel at the phases of medicine and surgery which have not yet been discovered.

Furacin

The yellow, glittering stuff I saw today looked like finely ground gold, but it wasn't. It was furacin. This a new, powerful drug that promises to take its place alongside the world's most effective germ killers. Its common source is plain, ordinary oat hulls — the same oat hulls which come from the great plains of the midwest.

Furacin already has established itself for effectiveness in the treatment of infected battle wounds. It is credited with saving a leg or an arm for many a soldier, who returned home with a wound that would not heal. It has proved itself a weapon against infection in skin grafting operations, in the treatment of diabetic gangrene, furuncles, surface ulcers, and infections resulting from burns. It does double duty in that it attacks both positive and negative type bacteria. In some cases, it prevents growth of infections; in others it kills. Much laboratory work to find out new secrets of furacin is now being done.

— Paul F. Ellis

New Wing Opened

Halifax Tuberculosis Hospital, operated by the City of Halifax, has opened a new 69-bed addition to its building, more than doubling the bed capacity of the institution. Other changes and improvements are the installation of x-ray equipment, modern operating-room, and new kitchens and staff quarters.

Under the Nova Scotia Government's free treatment policy sufferers from tuberculosis are treated at this and other tuberculosis hospitals in the province without cost.

Halifax Tuberculosis Hospital is operated by the Halifax Department of Health and Welfare, headed by Health Commissioner, Dr. Allan R. Morton. Dr. Charles J. W. Beckwith is the hospital's medical superintendent.

STUDENT NURSES PAGE

Pott's Disease

Sister Thomas Joseph

Student Nurse

Halifax Infirmary School of Nursing, N.S.

Betty, aged sixteen, was admitted to the ward in the forenoon of a bright September day. She was in a body cast extending from the axilla to the thigh. This plaster jacket had been applied by an interne ten days previous to her admission at another hospital. A superficial examination, while removing the patient's clothing, revealed that Betty had received good nursing care before being placed in our charge. Her teeth and hair also spoke of careful attention.

A routine urinalysis was done and the patient's history taken. The latter revealed the following:

Present complaints: Pain in upper part of spine.

Past illnesses: Ordinary diseases — apparent good recovery.

Present history: In May, the patient began to experience a cramp-like sensation and mild pain in the spine, between the lower borders of the scapulae. The pain became worse as time went on and walking was difficult. Sleep was disturbed and occasionally Betty awakened with quite severe pain. The doctor was called, x-rays were taken and a plaster cast applied in July. It had been changed twice previous to admission. Betty has been in bed since the application of the first cast, has had no further pain, and she now feels well, has no cough, night sweats, nor loss of weight.

The *diagnosis* of Pott's Disease was made.

"Pott's Disease is tuberculosis of the vertebral column. The lesion is situated in the anterior part, or in the bodies of the vertebrae." According to the author "the objective in treatment is to cure without curvature, and in order to cure do not open any abscesses." To cure without curvature, he goes on to say, "make good plaster corsets. Pott's Disease may remain unobserved, but generally makes itself known by some radiation or local pains, intermitting or by functional weakness, accompanied by reflex muscular contraction, defective walking, etc."[1]

From the patient herself, I learned that her illness had been caused by a fall. Her foot had caught in a railroad tie and she had tripped and fallen on her face. No sign of injury was evident until a few days later when pain in her back caused great discomfort. She said nothing about this to her mother until one night she cried aloud in her sleep and on being questioned told that she had hurt her back. X-rays were taken and the last group (with the present doctor in attendance) showed almost complete destruction of the eighth dorsal vertebra on which the seventh had fused with a moderate kyphosis, or lesser curvature of the spine. This showed the disease was not quiescent and that to arrest its progress an operation was imperative.

During the course of preoperative procedures, Betty and I became quite friendly and I learned something of her home environment. Besides her mother and father, she had an older married sister and a brother of nineteen. The latter was at present the sole support of the family. Monetary conditions were a source of anxiety. Betty's father, formerly engaged with a steel company, is now confined to a sanatorium where he is receiving treatment for pulmonary tuberculosis. Betty was quite optimistic about his recovery and did not seem aware of the poor financial standing of the family. One of the service clubs was paying all Betty's expenses and also helping to take care of the bills incurred at the sanatorium. Betty had a pleasing personality and made friends easily. This was a great asset in her long convalescence, as many of the patients who had come and gone during her illness came back to visit her.

In the afternoon of the patient's admission, the attending physician removed the body cast and placed a pillow under the affected area. The same evening the pillow was replaced by a blanket roll under the mattress. In the meantime a fracture board had been placed under the mattress. Betty did not like this but did not complain further when told the doctor wished pressure at the site of injury. The next day Betty was weighed because Avertin was to be given rectally. This was no easy task considering the length of time Betty had been confined to bed. However, with the aid of another nurse, her approximate weight was obtained. Betty was then taken to the operating-room, where, according to the report on their record, "a plaster shell was made up, with the patient suspended on a Bradford frame; some extension of lumbar spine was noted. The front was cut out of the jacket in order to remove it."

The surgeon intended doing a bone graft and wanted the patient put in a cast immediately after the operation.

Tuberculosis of the spine may be treated by operation in some cases, the principle of all the types of operation being to fix the spine in one position. In some types, a bone graft, usually from the tibia, may be removed from the leg and transplanted so as to unite the vertebrae. In such cases it is necessary to prepare the leg as well as the back for the operation.[2]

Betty's back was prepared from the nape of the neck to the sacrum and her left leg from knee to toes. This was a two-day preparation with a lapse of approximately twenty-four hours between the preliminary and final preparation.

The preliminary procedure consisted of shaving the areas to be prepared. Both areas were scrubbed for twenty minutes with a soft brush, using soap and water and changing the water three times. Sterile salt solution was used next and then, using sterile sponges saturated with alcohol, the areas were scrubbed for five minutes, washed off with ether, and allowed to dry. Sterile dressings were then applied. After a lapse of twenty-four hours, with "scrubbed hands" the areas to be prepared were again scrubbed for five minutes with a soft brush and liquid green soap, then scrubbed with alcohol and sterile sponges, washed off with ether, allowed to dry, and covered with sterile dressings. So much precaution was taken because of the danger of infection and the drastic consequences that would follow such infection.

The night previous to the operation a soap-suds enema was given. In the morning, the patient had no breakfast and morphine gr. 1/6 was given to relieve the patient's apprehension, together with atropine gr. 1/150 to diminish the secretion of mucus. This medication was given fifteen minutes before the administration of the Avertin, the latter being given rectally on the carriage.

The operation itself was long, approximately three and a half hours, and Betty was given a transfusion of glucose and saline during the procedure to lessen the shock that prolonged anesthesia entails. Twenty-five thousand units of Penicillin were also given in the operating-room with orders to give 20,000 units every three hours until 300,000 units had been given. Penicillin was given for its bactericidal effect. Morphine gr. 1/6 was also ordered for pain when necessary.

The operation over, Betty was placed in the cast previously made. This partial body cast enveloped the back and sides of the body but left the ventral area free. It was held in place by an abdominal binder fastened with three pins. The patient was then placed on her back in her own bed which had been taken to the operating-room.

Kept warm, with plenty of fresh air, Betty did not give evidence of great distress, apart from the usual vomiting and burning thirst. These conditions, due to the prolonged anesthesia, did not cease until forty-eight hours after her return to the ward. Starting with toast and tea, Betty was soon able to be on a general diet.

Pressure under the axilla and around the area of the buttocks caused great discomfort. The former was relieved by having the cast "cut down" and the latter by padding the lower end of the cast with abdominal pads. These were changed after the administration of the bed-pan (slipper pan), as well as night and morning. The heel of Betty's good leg began to get tender. A "cotton doughnut" was made to relieve this discomfort. Her left leg, from which the bone had been taken, gave little trouble. The sutures were removed, the area swabbed with alcohol, and in a little over a week it was sufficiently healed for the removal of all dressings and bandages. The patient's back also healed rapidly and in due time the sutures were removed. Both incisions had healed by primary intention, without infection. By the fourth week, the cast could be removed twice a week and the patient's back washed, rubbed with alcohol, and powdered with ordinary dusting powder. Formerly Neoderm had been used but, being of a coarse texture, it had caused itchiness. The patient looked forward to this treatment but was always glad nevertheless when the cast was on again.

Of a happy disposition, Betty from the start had been a favorite in the ward. She was plucky, had a sense of humor and, despite a lack of culture, had an innate refinement that charmed. Despite her sixteen years she was still much of a child. Her mother had left three days after the operation so various devices had to be thought of to keep her from getting lonesome. For awhile, Betty took delight in making paper bags. The novelty soon wore off and she tried reading. Much of the reading material that finds its way into a ward is not always suitable for a teen-age child, so certain books from the hospital library were selected to suit her taste and temperament. One in particular was a great favorite — "I was a Probationer." It kept her amused for days. Betty had decided to become a nurse and so anything that touched on the subject was of interest to her. She had Grade IX and I explained to her the necessity of completing her education if she wanted to realize this ambition. This also revived her waning interest in school and she began to make plans for studying in the summer to prepare for her re-entrance into school. She said her mother was anxious to have her continue her studies.

One day, Betty had the blues! With the doctor's permission I set to work to wash her hair. She was particular about her appearance if not exactly tidy by nature. She forgot her troubles as I dried her hair and put it up in pin-curls. All this took a great deal of time but it was well worth the effort. Smiles instead of tears were the order of the day.

Betty is now able to write letters home but cannot feed herself yet, due to her position. This is not to her liking but she found it too awkward and tiring to do otherwise. Soon she will be put into a complete body cast and taken home to complete her convalescence. All in all, this has been a very interesting case.

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1. Calot, T. Indispensable Orthopaedics. 2nd Ed.
2. Eliason, Ferguson and Farrand. Surgical Nursing.

Letters from Near and Far

The Place of the Buck Deer

Pangnirtung, Baffin Land, lies in a fiord which leads into Cumberland Sound from the northeast. Temperatures range from about 60 above, in the shade, during the summer to 50 below in winter. Growth is confined to mosses, lichens, grasses, dwarf willows flowering shrubs, with sometimes a few blueberries and mushrooms. Some of the flowers give off a lovely perfume. The so-called Arctic night descends about the middle of December and lasts till the end of January. However, the sun can be seen patting the mountain tops all winter if the weather is clear. In May, it is light at midnight and daylight is continuous during July. From Mt. Duval, which is 2,250 feet, or from the sides of the hills behind the buildings, the view is marvellous. Rocks rising 1,500 feet; jagged peaks in the distance towering to 5,000 feet; clouds caressing the mountain's cheeks, playing hide-and-seek or romping half-way down the slopes; browns and reds of vegetation in the foreground all tinted by the sun and mirrored in the mighty waters is a picture worth seeing in the summer. Winter is no less beautiful when the mountains don their royal ermine mantles and the clouds in mauve, amber, baby pink, and blue hover in attendance. The scenery combines my love of England's rugged Cornish coast and the Canadian Rockies. There is a sense of massive might creating an austere affection which I find inspiring and protective.

We have a tide ranging from twelve to twenty feet. At the head of the Sound it reaches about thirty-eight feet. The water is very deep in the fiord. In front of the settlement there is an unusual rock rampart fronting a boulder-strewn platform at low tide. The fiord extends some thirty miles inland. The settlement is about eight miles within the entrance.

There are only twenty buildings in this pioneer community, including the R.C.M.P., Hudson's Bay Company, and the Anglican Mission Hospital with a rectory which includes the church. The white population is eleven adults and three children. Eskimo of the district number 551 and are scattered at twenty-four camps. Only about twenty-five stay at the post.

The St. Luke's Mission Hospital, supported by the Church of England and by Government grants, is a long one-and-a-half storey building. The hospital was built in 1930 but is not as well equipped or furnished as the Aklavik hospital. This hospital and the Government doctor serve a huge territory, the nearest medical unit being at Chesterfield, Hudson's Bay. It can accommodate twenty-six patients and two nurses on the main floor while five rooms upstairs serve for kitchen, matron's quarters, and eight indigents. Our own Delco plant generates current for electric lights, x-ray, and combination gasoline-electric ironer. No electric washer, hand-iron or sterilizers are in use here. There is an operating-room, Nuffield iron lung, sunray lamp, six wards, and one private room.

Six stoves heat the building. Three in the hall, one in the kitchen, and a 2 x 4 for the indigents are all coal-consumers while in the combination living and dining-room is a lovely oil burner. What a pleasure to handle coal after nine years of relying on wood at Aklavik and Fort George! Incidentally, coal costs $100 per ton and gasoline $1 per gallon here; ours is purchased "outside."

The two nurses find it most satisfactory to work days taking alternate nights on call, there being no suitable accommodation for daytime sleeping. Medications, even penicillin every three hours, can be administered with the help of the alarm clock, but when necessary nineteen and even twenty-four hours' active duty is done. There are seldom more than eight patients. This year is a record in many ways with over fifty admissions with several operations under general anesthesia.

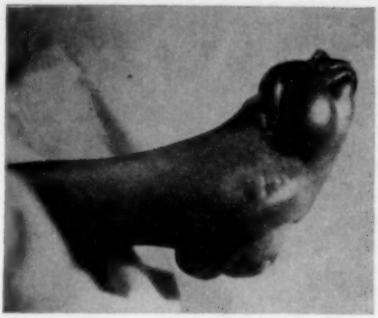
Only a few of the hundreds of Eskimo can speak English. They are still very primitive and shy. They feel that a weekly bath with a daily morning wash is really quite sufficient for any patient. Most of our cases are malnutrition, pneumonia, tuberculosis, severe frost-bites, and minor injuries, with three tonsillectomies, six major operations, and several casts applied this year to make history. The number of mental cases is disturbing. Scabies has worked northward causing complications which have resulted in deaths where treatment was not available. In a more northerly post thirteen died. Many of the thirty-four deaths occurring in our district, three in hospital, seem to be due to the fact that if the patient does not wish to eat, drink, or be moved he is not disturbed or crossed by the Eskimo. I sincerely hope we can soon remedy this by giving the native girls elementary home nursing, adaptable to igloo and tent life. The natives handle their own maternity cases, none coming into hospital. Many children have umbilical hernias. Babies are nursed until about four years of age.

Eskimo girls do the washing and ironing for the hospital under supervision of the kitchen matron and help with general cleaning. The three staff members do their own interior painting and spring cleaning. An Eskimo man does the chores.

There are no plumbing facilities. In summer, wash water is secured from a little creek near our building while for drinking purposes the dog-team draws barrels overland from a river about two miles away. During winter months, September to May, ice is hauled in boxes and snowblocks are cut from the snowdrifts to provide water.

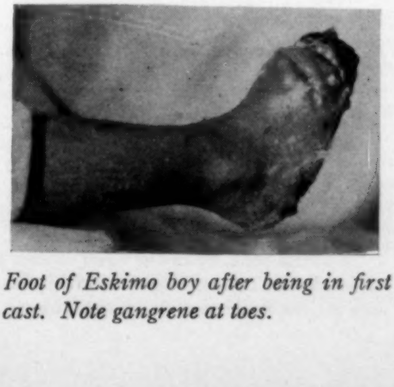
Diet is a problem. The natives rely on seal, fish, and caribou. If hunting is poor and foxes scarce (none were caught last year) they have nothing with which to buy even tea and flour to tide them over. We enjoy seal, fish, caribou, rabbit, walrus, and even owl when we can get it.

All the people in the district are being inoculated against typhoid fever and diphtheria. May I tell you about some trips I had this year? October 25 found the doctor, his wife, native man, Etwana, Kunya, his boy, and me walking over snow and ice at 9 a.m. to climb into Etwana's boat (whaleboat with 5 horsepower engine) heading for the camp of Avatuktoo twenty-five miles away. We were clothed in furs, seated on a polar bear skin, and racing the elements, carrying our rations, tent, and medical supplies. About twelve noon, Etwana manoeuvred the boat around, excitedly saying it was too rough. Though the waves coming over the bow washed us, then coated us with ice, I did not realize there was anything to fear. At length we gained the shore and, sheltered by rocks, made tea with the aid of the primus stove. The pilot biscuit, crowned with a slab of Spork, tasted better than a turkey sandwich amid the intense vast solitude. We returned homeward without unnecessary delay.



Frozen foot of Eskimo boy at Pangnirtung, Baffin Land.

On January 22 the four of us set off again this time on komatiks pulled by dogs. We left at 9.30 a.m. and reached our destination about 4.30 p.m. The temperature being 50° below, it was too cold to pitch our tent. An igloo would have been warmer, but the snow was not suitable to make one so we shared one of the native's igloo-like skin tents which was covered with snow. We found some sickness. They were low on supplies and had very little seal-oil for fuel. Usually an igloo this size burnt three coodlies (seal-oil lamps) but only one tiny flame was visible. A boy with both feet frozen had been taken to the hospital a day or two earlier. There he responded well to penicillin and casts. We crawled into our sleeping bags early, six in a row on the slightly raised platform and were up again at 6 a.m. The clothing I wore was amazing but I did not even freeze my nose despite 45-50° below. Woollen vest, two pairs of woollen pants, men's size 38 underdrawers, duck breeches, three sweaters, duffle koolata (parka), caribou koolata, caribou pants, golf



Foot of Eskimo boy after being in first cast. Note gangrene at toes.

Nearly well again

hose, caribou hip-length socks, caribou boots wool mitts, fur mitts, and beret! Natives wear two complete caribou suits.

On July 3 I had the privilege of making a short trip, without the doctor, inoculating at three camps—Avatuktoo, Ooshualoo, and Noonata. In the aforementioned boat we covered the hundred miles in twenty-four hours. Needless to say, we ate and slept while Etwana ran the boat. The poor natives were roused whenever we arrived, even at 3 a.m.

On July 26, with Dr. and Mrs. Gaulton the singular honor was mine to be the first nurse to make a 350-mile trip calling at Bon Accord, Imegan, Ilkaloolik, Nowyapik, Iglootalik, Openlevek, Krepashau, and Kimiksoon camps. Being so close to Blacklead Island, we could not resist the temptation to go ashore and see the relics of the historic whaling station and early missionary base of Dr. Peck in 1894. We managed to complete the tour in five days. It must be the "Thousand Islands" of the eastern Arctic. Ragged, wrinkled, barren, rocky islands of every size abound. I am amazed the people are so clean for truly they are "children of the rocks" living off the country. It would add greatly to the comfort and efficiency of these visits if the Government or mission would provide a boat with a cabin. However, I am grateful for having seen some of our people in their natural environment, just another sustaining picture for those times of loneliness and doubt when we wonder if it is worthwhile or if we should have our heads read for coming North!

Mail comes via the *Nascopie* in September and sometimes by dog-team once during the winter, about March. This year a plane, parachuting the medical supplies which had missed the boat, dropped us a few letters in October. One never can tell when the planes might decide to bring us mail oftener—wishful thinking!

—MILDRED VENNING RUNDLE

Book Reviews

Aids to Tuberculosis for Nurses, by L. E. Houghton, M.D. and T. Holmes Sellors, D.M., M.Ch. 262 pages. Published by Baillière, Tindall & Cox, London, Eng. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1945. Illustrated. Price $1.20.

Reviewed by Elsie J. Wilson, Central Tuberculosis Registry, Winnipeg, Man.

This little book, by two of Great Britain's authorities on tuberculosis, is written primarily for the nurse working in a sanatorium. However, in these days, when few nurses know anything about tuberculosis, beyond the fact that it is a communicable disease, it could be read with profit by all.

Some of the information about the tuberculosis problem is not applicable to Canada and some of the methods are different to those in use here, but the nature of the tuberculosis problem stated in Chapter 1 is the same in Canada as in Great Britain.

Information, about tuberculosis in its various forms and degrees of activity, is clear and concise, as are discussions on various methods of treatment. The drawings and x-ray plates reproduced in the book are clear and helpful in explaining the text.

It will be a happy day for tuberculous patients when nurses put into effect the authors' concept of what constitutes good nursing care.

Medicine in Industry, by Bernhard J. Stern, Ph.D. 209 pages. Published by The Commonwealth Fund, 41 East 57th St., New York City 22. 1946. Price (in U.S.A.) $1.50.

Reviewed by Winnifred Ruane, Industrial Nurse, Vulcan Iron Works, Winnipeg, Man.

The economic, social, legal, and professional aspects of medicine in industry have been widely surveyed in this book by Dr. Stern, lecturer in sociology, Columbia University, and member of the Committee on Medicine and the Changing Order, appointed by the Council of the New York Academy of Medicine.

Dr. Stern deals with the social and legislative background, industrial disability rates, and the limited extent of preventive services. He describes the development of health insurance, the participation of trade unions in health programs, and the relation between the industrial physician and general practitioner. Particularly worthy of mention is a chapter on the handicapped worker where the author shows that, through fair pre-employment examination, job analysis, and proper placement, the handicapped worker has established a good record in industry. The contents of this chapter provide enlightening data for industries lacking a fundamental rehabilitation program that is so essential today.

Although considerable advancement has been made in industrial medicine, Dr. Stern's facts and figures leave the impression that there is great need for further development in providing adequate medical care to serve the vast numbers working in industry, especially in the smaller plants.

This book does not contain material in detail to be used as a working manual but it is valuable to all those who wish to know the social aspects of medicine in industry.

Diabetic Care in Pictures, by H. Rosenthal, B.S., F. Stern, and Joseph Rosenthal, M.D. 150 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1946. 137 original illustrations (4 in color). Price $2.25.

Reviewed by Sister M. Claire, Instructor, St. Joseph's School of Nursing, Victoria, B.C.

The authors of this book have given us a clear, attractive and long looked for, simple, but still a complete, diabetic treatment manual, which will find its place on the library shelves of all those interested in the welfare of the diabetic patient. It will be of value to the physician, the dietitian, the nurse; but its greatest value will be to the patient himself, whose safe guide it should be, for it will help him to understand his treatment and teach him how he may carry it out successfully.

This small volume contains many illustrations, all preceded or accompanied by clear explanations. The method used to impart knowledge regarding every phase of diabetic care is gradual, precise, and covers every topic needed to convince the patient of its importance. A new and practical aspect is the use of illustrations referring to food exchanges, which should be of immense value to the patient, who is so easily worried and perplexed when the necessity for substitutes arises. Moreover, these illustrations will help him adjust his diet to the family diet, and choose the right food outside the home, when required.

This book should appeal to both the patient and his family, and help make the diabetic treatment a success, for it meets the patient's needs, physical and mental, as no other manual has done before, and can justly be considered as another "precious gift" for the diabetic patient.

Physiology and Anatomy, by Esther M. Greisheimer, M.D. 841 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 5th Ed. 1945. Illustrated. Price $3.75.

Reviewed by Mrs. Virginia Pearson of Edmonton, Alta.

The fifth edition of this well-known text presents only a few changes. Revisions have been made in the chapters on the nervous system, temperature regulation, and a very good chapter has been added on the physiology of aviation.

The introduction to the anatomy of the

nervous system begins with the functions of the nervous system in relation to the body's response to environment. The section on nerve fibres is more clearly presented and there is more detail on the divisions of the nervous system and some explanatory definitions. The order of presentation of the parts of the system is changed, introducing first the meninges, brain, divisions of the brain, spinal cord, then the cranial and spinal nerves. The distribution of spinal nerves is discussed more fully than in the previous edition.

The chapter on the physiology of the nervous system has been re-arranged to correlate with the chapter on the anatomy of the system. On the whole these two sections present a more logical and clearer picture of the nervous system.

The chapter on temperature regulation has been re-arranged somewhat.

The chapter on the physiology of aviation gives a detailed account of the effects of altitude on the human body, concluding with the special duties of the nurse employed in aviation.

Alberta Department of Public Health

Helen McArthur has resigned as superintendent of public health nurses to become director of nursing services for the Canadian Red Cross Society. *Jean S. Clark* has replaced Miss McArthur. (See Interesting People, Nov. 1946 issue.)

Beth Laycraft has left Hines Creek for a year's leave of absence which she is spending in public health work at Chilliwack, B.C. *Elizabeth Lea* has left Peers and has been doing relief work. *Aletha (Knudson) Glasgow* after her marriage is remaining with Wainwright health district and *Marie (Dufresne) Lessard* is continuing at Tangent. *W. Berhman* has left the Sunnynook district to attend the University of British Columbia and *Augusta Evans* the Hilda district to take her Master's Degree at Columbia University. *Mrs. Barbara Eben* has been assisting in the Division of Public Health Nursing office while *Miss Clark* is visiting in the districts.

Appointments: *Marguerite Weder, B.Sc., P.H.N.*, to Lindale; *Katherine Brandon* to Grassland, after five years, including service overseas, with the R.C.A.M.C.; *Barbara Taylor* to Maloy; *Lillian White* to Valley View.

Transfers: *Frances Smith* from Newbrook to Hines Creek; *Ethel Jones* from Foremost to take over the Peers district; *Jean Blackbourne* from Grassland to Foremost; *Mrs. Nina Renwick* from Whitemud Creek to Blueberry Mountain.

Resignations: *Mrs. Edith Bennett*, of Grouard, to return to England; *Mrs. A. V. Cavil* from Lomond; *F. M. Harrison* to return to Manitoba.

Retirements: *Amy Conroy* from Pendryl after twenty-six years with the Department of Public Health; *Olive Watherston* from Lindale after twenty-five years with the Department; *Blanche Emerson* from Child Welfare Clinic, Edmonton, after twenty-six years with the Department. (See Interesting People, July, 1946 issue.)

Useful Hints

In the Gull Lake Union Hospital (Sask.) some useful ideas have been put into practice which might be adopted with advantage by other hospitals. The first is our method of wringing stupes. We have an ordinary clothes-wringer, fixed on a stand over one of the bath tubs in the service room. A quick turn of the handle and the stupe is dry with little loss of heat. There is no danger of getting a burn from the hot water as the waste runs down the drain in the tub.

Another useful and saving method we use here is covering our ice collars with the ordinary stockinette which is used under casts. After each tonsillectomy we can wash them and they can be used again.

— GEORGIA F. JOHNSTON

Nursing Sisters' Association of Canada

The following officers comprise the National Executive of the Nursing Sisters' Association of Canada for the coming biennium, 1946-48: Honorary presidents, Margaret Macdonald, R.R.C., LL.D.; Edith Rayside, R.R.C., C.B.E., M.Sc.; Mrs. Stuart Ramsey; president, Mary Edgecombe, World War II, Saint John, N.B.; first vice-president, Mrs. A. B. Walter, World War I, Saint John; second vice-president, Mildred Titus, World War II, Saint John; third vice-president, Mrs. C. A. Young, World War I, Ottawa; secretary-treasurer, Hazel Vallis, World War II, 64 Albert St., Saint John, N.B. Councillors, Edith Dixon, World War I, Saint John; Sara Miles, World War II, Rothesay. President, Saint John Unit, Ada Burns, World War I.

In May, nursing sisters of the *Halifax Unit* attended National Vesper Services at St. Mary's Cathedral and St. Andrew's Church. On November 11 a number of nursing sisters attended the Memorial Service at the Cenotaph and the wreath was placed by Sadie McIsaac, R.R.C., and J. Hubley. In the evening the annual dinner and meeting were held in the Nova Scotian Hotel with thirty sisters present. M. Haliburton, the president, welcomed the new members. Sadie Archard, R.R.C., gave an interesting report of the nursing sisters' biennial dinner and meeting held in Toronto.

Officers elected for 1947 include: President, Jean Nelson, R.R.C.; secretary, Georgina Thompson; treasurer, Lillian Fitzgerald.

A "Welcome Home" party for nursing sisters of World War II was held last May by the *Hamilton Unit* when twenty-one new members joined the unit. In July many members attended the biennial meeting and dinner held in Toronto. The president, Mildred Cowan, attended the executive meetings. She and the present executive have carried on for many years, the unit having few members. With new and younger nurses joining the unit it is planned to pass the reins of office on to them at the annual meeting.

A general meeting of the *Montreal Unit* was held in October when forty-nine members were present, including twenty-two sisters of World War II who joined the association that night. Mrs. W. Ramsay gave a detailed report of the biennial meeting. On Remembrance Day the annual dinner was held when 130 members attended, including twenty-five sisters of World War II who joined the association. General Walford was the guest speaker. The president, Mrs. Stuart Ramsey, presided. It is interesting to recall the fact that she was the one who started the Nursing Sisters' Association. At the services held earlier a wreath was placed on the Cenotaph.

The fifteenth annual meeting of the *Ottawa Unit* was held on November 11. This was preceded by a luncheon at which sixty-eight nursing sisters were present, thirty-eight of whom were veterans of World War II. Mrs. H. J. Coghill, the president, addressed the members and extended a welcome to the nursing sisters.

A farewell tea for Blanche Anderson, who has left Ottawa, was held in September, when she was presented with a corsage. At the conclusion of the tea, the flowers and food were taken to the patients in the Veterans' Pavilion of the Civic Hospital.

On Remembrance Day a wreath was placed on the Cenotaph by Mrs. C. A. Young for the National Executive.

Officers elected for 1947 include: President, Gertrude Garvin; secretary, Maud Hill; treasurer, Gladys Clark.

The *Regina Unit* reports monthly social gatherings to welcome home returning nursing sisters. The Canadian Legion is planning a Memorial Hall and the unit has asked for a room in it for which they plan to be responsible. Members have acted on convoy duty — from Winnipeg to Calgary — with British brides. During the year a Florence Nightingale Service was arranged in one of the churches and nurses attended in a body. Flowers were placed in the cemetery on Decoration Day in May and a wreath of poppies at the Cenotaph on Remembrance Day.

The *Saint John Unit* has held three general meetings and one executive meeting during the past year. Sisters attended the National Vesper Services in May and Mary Edgecombe placed a wreath on the Cenotaph on November 11. At the annual dinner and meeting forty-seven nursing sisters were present, a large majority of whom were veterans of World War II. Greetings were received from thirty-nine absent members from the U.S.A. and all parts of Canada. To date the unit has presented complimentary membership to 104 discharged nursing sisters. In June the new members of the unit held an enjoyable picnic when nursing sisters of World War I were their guests. Individual members of the unit contributed $109 to the Saint John branch of the Canadian Legion, when they put on their campaign for the Memorial Building Fund.

Officers elected for 1947 include: President Ada Burns; secretary, Mrs. Earl Jamieson; treasurer, Mrs. John McCoubrey.

Several executive meetings were held by the *Vancouver Unit* and at the general meeting $500 was voted from the War Activities Fund for the Nurses Rehabilitation Fund to be used for British nurses. A tea was held at the home of Mrs. L. W. McNutt, honoring nursing sisters of World War II. The annual picnic took the form of a delightful day-boat trip up the West Coast. The outstanding event of the year was the opening of the new T. B. pavilion at Shaughnessy Hospital as a memorial to the late Jean Matheson, beloved first matron and first president of the unit. The nursing sisters of World War I were among the special guests. A memorial from the unit will be placed in the pavilion. On Remembrance Day members attended services when a wreath was placed at the Cenotaph by the acting president, M. McCuaig. The sisters' graves in the "Field of Honor," Mountain View Cemetery, were decorated with flowers and a wreath placed at the "Shrine." Of the large number who attended the annual Remembrance Day dinner 120 were sisters of World War II.

News Notes

NEW BRUNSWICK

MONCTON:

Margaret E. Kerr, editor of *The Canadian Nurse*, was the guest speaker at a recent meeting of the Moncton Chapter, N.B.A.R.N. She gave an interesting description of the work entailed in preparing a magazine for publication. The following evening several nurses motored to "Rockaway" and enjoyed a pleasant dinner with Miss Kerr, who was the guest of honor. A book of poems by C. G. D. Roberts was later presented to her.

SAINT JOHN:

At a recent meeting of Saint John Chapter N.B.A.R.N., with Miss Down presiding, Margaret Murdoch gave an interesting report of the N.B.A.R.N. executive meeting. Dr. W. J. Fisher read an instructive paper on "Shock Therapy."

At a supper meeting of the Public Health Section, Saint John Chapter, Muriel Clark presided, with twelve members in attendance. A talk on "Art" was given by Norman Cody after the business meeting.

General Hospital:

Fern Townsend is sending well-filled boxes to an English nurse on behalf of the alumnae association. Dr. and Mrs. George (Price) Dewar are residing in Bedeque, P.E.I., where Dr. Dewar has started a private practice.

Provincial Hospital:

Shirley Kilpatrick, Edith Wile, Bernadette Richard, and Mrs. Irene Duplessis have joined the staff.

St. Joseph's Hospital:

At a recent well-attended meeting of St. Joseph's Hospital Alumnae Association, held in the form of a shower, many gifts were received. Two boxes were packed, one to be shipped to France and the other for a British nurse.

Mona McDermott replaces Rev. Sr. Delphine as supervisor of the central dressing room and Rev. Sr. Germaine is assistant night supervisor.

ONTARIO

EDITOR'S NOTE: District officers of the Registered Nurses Association may obtain information regarding the publication of new items by writing to the Provincial Convener of Publications, Miss Gena Bamforth, 54 The Oaks, Bain Ave., Toronto 6.

DISTRICT 1

CHATHAM:

A recent meeting of the Chatham Public General Hospital Alumnae Association was held at the home of Mrs. Gordon Webster, when plans were made for a forthcoming bazaar, convened by Annie Head. Jean Ross gave a report of the R.N.A.O. annual meeting. Five dollars was donated to the Little Women's Club. Miss Head, on behalf of the alumnae, presented a bouquet of roses to Priscilla Campbell, congratulating her on her appointment as president of the Ontario

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Hospital Association. (See Interesting People page in this issue.) Following court whist the hostess served lunch, assisted by Jean Ross, Mmes Ray Beable and Gordon Brisby.

DISTRICT 4

At a recent well-attended meeting of Niagara Chapter, District 4, R.N.A.O., nurses from Niagara Falls, St. Catharines, Fort Erie, and Welland were present. Catharine O'Farrell, the chairman, gave a comprehensive report of the R.N.A.O. annual meeting. Reports were also received from the general nursing, hospital and school of nursing, and public health sections. The guest speaker was Dr. L. W. C. Sturgeon, M.O.H. for Welland and district health unit, whose talk was entitled "Public Health." He stressed the fact that the idea of health units was not new, that they were talked about fifty years ago as an aid in raising the standard of health in the community.

DISTRICT 5

At a well-attended meeting of District 5, R.N.A.O., held at Barrie, Ethel Johns was guest speaker and presented a stimulating address on "Which Way the Wind is Blowing." Claribel McCorquodale, the chairman, presided.

The annual meeting of the district will be held in the Royal York Hotel, Toronto, on February 17. Dr. Leslie R. Angus, director of psychiatric services, Devereux Schools, Devon, Penna., will be guest speaker.

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Margaret O. Cogswell, Director, St. Stephen's College, Edmonton, Alta.

REGISTERED NURSES' ASSOCIATION OF BRITISH COLUMBIA

(Incorporated)

An examination for the title and certificate of Registered Nurse of British Columbia will be held on March 18, 19 and 20, 1947.

Names of Candidates for this examination must be in the office of the Registrar not later than February 18, 1947.

Full particulars may be obtained from:

ALICE L. WRIGHT, R.N., Registrar,
1014 Vancouver Block, Vancouver, B.C.

Toronto East General & Orthopedic Hospital:

At the annual reunion dinner of the Toronto East General and Orthopedic Hospital nurses' alumnae, the Hon. Russell T. Kelley, Minister of Health for Ontario, was the guest speaker. The dinner was held in the beautiful main dining-room of the T.E.G.H. and for the majority of the nurses present it was the first time they had the pleasure of dining in the new addition to their alma mater. A choir, composed of student nurses, provided music, and J. Mathews, of Renfrew, a preliminary student, rendered two solos. Lorna Warman, alumnae president, was in the chair, and Dr. J. Ferguson, chief of staff, and Mr. J. Harris, M.P., of the board of governors, were among the speakers. The banquet was convened by Mrs. R. Taylor and Florence Kane.

DISTRICT 6

At the annual meeting of District 6, R.N.A.O., with Mrs. E. Brackenridge, the chairman, presiding, there were approximately thirty-five members present. Florence Walker, associate secretary of the R.N.A.O., addressed the meeting and brought to the district much valuable information. Sixty-five members were in attendance at the dinner and the guest speaker at the evening session was Edith Dick, of the Nurse Registration Branch, Ontario Department of Health. A. Machala, of Batawa, was elected chairman of the district for the coming year, with Sylvia Weaver, of Belleville, as secretary-treasurer.

Reports from the various sections and chapters revealed that many interesting and worthwhile activities have been carried on during the past months. The highlights of these reports are briefly summarized as follows:

Chapter A: The graduation class of Belleville General Hospital were guests at a meeting when Mrs. Grant Sparling spoke on 'Social Service Workers." Edna Sullivan's address on "Nursing in Africa" was the highlight of one of the chapter's meetings. Donations are being received for scholarships for post-graduate work from various organizations.

Chapter C: Films on oxygen therapy and venereal disease have been shown to the graduate and student groups. The public health section revealed the organization of the Northumberland and Durham County health units. Panels on "Health Work in Industry" were conducted under the auspices of the Health League of Canada. L. Stewart was the delegate to the C.N.A. convention and presented an interesting account of the meetings.

LINDSAY:

Ross Memorial Hospital:

Aileen Flett, instructress, has resigned.

PETERBOROUGH:

Civic Hospital:

Annie L. Thomson succeeds Edith Young as director of the school of nursing. (See Interesting People, Dec. 1946 issue.) At the last graduation exercises ten students received their diplomas and four scholarships for post-graduate courses were awarded. M. Robson and M. Langmaid have returned to the staff after post-graduate work at the University of Toronto School of Nursing. L. Pickering, head nurse in the operating-room, has received a scholarship for post-graduate study.

St. Joseph's Hospital:

The medical staff has established an annual scholarship for post-graduate study, to be awarded at the graduation exercises. I. Walsh has completed a course in obstetrics and has returned to the staff. Sr. Gonzaga is attending St. Louis University to complete her degree in nursing education.

DISTRICT 8

Ottawa General Hospital and University of Ottawa School of Nursing:

On her retirement from active nursing following twenty-one years of service as night supervisor at the Ottawa General Hospital, Isabel McElroy was entertained at dinner by the hospital staff and later at tea by the alumnae association. On both occasions suitable presentations were made. (See Interesting People, Dec. 1946 issue.)

Sr. M. Alban has been elected president of the Ontario Catholic Hospital Association. F. Fournier is now with the Metropolitan Life Insurance Co. J. Page has been appointed to the Russell-Prescott health unit. Marie-Reine Nadon has been named field secretary of the Ontario Junior Red Cross. Anita Mercier is industrial nurse with the International Paper Co., Gatineau Mills, P.Q. K. Bayley, H. Bechard, G. Clark, B. Poulin, and A. Soulière have accepted positions with the Ottawa City Health Department.

The following nurses are taking the public health course at Ottawa University: R. Adam, I. Johnston, L. LaRocque, M. Latremouille, H. MacDonald, and R. MacIsaac.

DISTRICT 10

At a meeting of District 10, R.N.A.O., held at Port Arthur General Hospital, Wilma Ballantyne gave an interesting account of the board meeting which she attended. Miss Spidell covered a few of the important topics discussed at the C.N.A. biennial meeting.

At a meeting of the Hospital and School of Nursing Section, held at the McKellar Hospital, Fort William, Dr. J. D. McIntosh lectured on "Anesthesia."

Mary Wright was responsible for the arrangements of a recent dinner meeting of the Public Health Section. Marjorie Copping gave a delightful talk, illustrated with pictures on her travels through Palestine and Indo-China. At the close of the meeting Elsie Wright, who has resigned from the Port Arthur Department of Health to be married, was presented with a gift from the the group by Violet Weston. The chairman, Bessie Jackson, presided.

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QUEBEC

MONTREAL:

Montreal General Hospital:

A farewell tea, attended by the medical and nursing staffs, was recently given in honor of Mabel K. Holt, former superintendent of nurses. At this time Miss Holt presented her portrait to the nurses' residence, a gift to her from the graduates of the hospital. We are pleased to welcome to our staff, Mary Mathewson, who has succeeded Miss Holt. The student nurses recently gave a tea in her honor. (See Interesting People, Nov. 1946 issue.)

Recent additions to the staff include: M. MacDonald, E. M. Sykes, M. J. McCann, P. E. Walker, K. MacIntosh, N. McKee, P. Dahms, P. Pugh, M. Hurren, W. Sproule, E. Jamieson, E. Lonergan. Mildred Brogan has handed over her duties as medical supervisor to Jean Anderson and is now classroom instructress.

B. Hillborg and J. Goodall have retired from the staff.

Recent visitors to the hospital were: Cluny MacDonald, of San Francisco; Miss Beck-Friis, of Sweden; Rachel McConnell, and Mrs. Melinda (Franklin) Wainwright, of California.

Royal Victoria Hospital:

Mrs. Jean (Fitz-Maurice) Wigham visited the hospital recently. She has been living in England for the past seven years and expressed her appreciation to the alumnae association for food boxes that had been sent to her and other members living over there.

Kathleen Dickson has resumed her work in public health nursing in Westmount. (See Interesting People, Dec. 1946 issue.) Mrs. E. (Williams) Fleming, who has been head nurse on Ward I, has taken charge of Ross 4. J. Bulman has replaced her and Tannis Hall will be her assistant. Ruth Curtis has succeeded Betty Winch, who left to be married, in the Ross operating-room.

SASKATCHEWAN

HUMBOLDT:

Sisters Marcella and Dolores recently completed an x-ray technician course at Winnipeg. Laura Madden, of Plato, is now public health nurse for Humboldt.

MOOSE JAW:

The public health nurses of Region No. 6 have begun immunization of city and rural school and pre-school children. The immunization and infant welfare clinics, held in the regional health centre, are in full swing and it is hoped that an ante-natal clinic will soon be established. M. Edy is a new addition to the public health staff.

M. Woolliams, who was industrial nurse at Swift Canadian Co., has left to take up residence in Victoria, B.C. M. Greenwood and R. Payson have accepted positions at the Community Hospital, Herbert.

General Hospital:

At a recent meeting of the Moose Jaw General Hospital Alumnae Association, Dr. F. Wigmore gave an interesting talk on his experiences overseas with the R.C.A.M.C. and commented on the fine work done by army nurses in the various units and field hospitals.

F. Steele is now on the staff.

Providence Hospital:

The hospital has purchased a former R.C. A.F. airport building which is being remodelled to provide a new residence for nurses. The new home will contain a reception room, canteen, demonstration and classrooms, and it will house from sixty to seventy nurses. The total bed capacity of the hospital will be increased to 200 when all nurses have moved to their new home.

Miss Straub, formerly on the nursing staff, is now with the Gull Lake Union Hospital.

REGINA:

General Hospital:

The nurses' Hallowe'en party was a great success, each class of students making a contribution to the program of skits and songs. Light refreshments were served and prizes awarded for the most original costumes.

Edna Larmour, ex-nursing sister, and recently on the staff of the Montreal Military Hospital, is now supervisor of the D.V.A. wing. I. Ficke is head nurse, male surgical ward.

SASKATOON:

An interesting film was shown to student and graduate nurses from St. Paul's and City Hospitals. The film, entitled "Poliomyelitis Clinic," was explained by Dr. H. D. Hart.

St. Paul's Hospital:

Rose Leier, a new appointment to the staff, will have charge of the health program. Hazel Arthur is on the nursery staff. Ann Beechinor and Fern Burger are taking a post-graduate course in pediatrics at the Children's Memorial Hospital, Montreal.

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Graduate Nurses for 200-bed hospital in Niagara Peninsula. Salary: **$100** per month plus full maintenance. Railway fare refunded after 6 months' service. Apply to Supt., County General Hospital, Welland, Ont.

Registered Nurses (**2**) for General Duty. Straight 8-hour shift; 44-hour week —5½ day week. Gross salary: **$126.50** per month. For further information apply to Miss E. W. Ewart, Supt. of Nurses, Mountain Sanatorium, Hamilton, Ont.

General Duty Nurses for 44-bed, fully modern hospital. Salary: **$100** per month plus full maintenance. Separate nurses' home. 8-hour day and 6-day week. 3 weeks' holiday with pay after a year's service. Apply to Supt. of Nurses, Municipal Hospital, Grande Prairie, Alta.

General Staff Nurses for Nursery. 8-hour day and 6-day week, rotating on 3 periods of duty every four weeks. Apply to Director of Nursing, Women's College Hospital, Toronto 5, Ont.

Assistant Superintendent. State qualifications and salary expected. **General Duty Nurses.** 6-day week. Hospitalization Plan. Salary: **$100** per month with full maintenance. Apply to Supt., Brome-Missisquoi-Perkins Hospital, Sweetsburg, P.Q.

Operating-Room Nurse for Chest Surgery. Eligible for British Columbia registration. Day duty only. 8-hour day; 5½-day week. Gross salary: **$125** with increments up to 7th year. Uniforms and laundry provided. 1 month vacation each year with pay. Superannuation. Sick leave with pay, up to 2 weeks for major illness and 6 days for minor illness, accumulative. Live out. Apply, stating qualifications and experience, to Supt. of Nurses, Vancouver Unit, Division of Tuberculosis Control, 2647 Willow St., Vancouver, B.C.

Nurses for Mission hospitals in North China. 3-year term. Work done through interpreters. Write to Candidate Secretary, Woman's Missionary Society, United Church of Canada, 299 Queen St. W., Toronto 2B, Ont.

Graduate Nurses for 50-bed Maternity Hospital. Apply, stating qualifications, salary, etc., to Supt., Catherine Booth Hospital, 4400 Walkley Ave., Montreal 28, P.Q.

Superintendent of Nurses for 35-bed hospital. Good accommodations and salary. Apply, stating age, experience, and references, to President, General Hospital, Digby, N.S.

Registered Nurses for General Duty. 8-hour day and 6-day week. 28 days' holiday with pay after 1 year's service. Commencing salary: **$125** gross. **Dietitian** also required. Apply to Supt. General Hospital, Kelowna, B.C.

Public Health Nurse for City of Galt. Salary: **$1,600.** Apply to Secretary, Board of Health, Galt, Ont.

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Operating-Room Nurse. Apply in person or write to Lockwood Clinic, 300 Bloor St. E., Toronto 5, Ont.

Night Supervisor, Instructress of Nurses, and **Dietitian** for 50-bed hospital. Apply, stating qualifications, experience, and salary expected, to Supt., Payzant Memorial Hospital, Windsor, N.S.

General Duty Nurse for a 20-bed fully modern hospital. Salary: **$100** per month and full maintenance. 6-day week. Apply to Supt. of Nurses, Municipal Hospital, Brooks, Alta.

Registered Nurses for General Duty at Vancouver General Hospital, British Columbia. State in first letter date of graduation, experience, reference, etc., and when services would be available. 8-hour day and 6-day week. Gross salary: $125 per month living out, with annual increases up to 7 years, plus laundry. 1½ days sick leave per month accumulative with pay. Employees' Hospitalization Society. Superannuation. 1 month vacation each year with pay. Investigation should be made with regard to registration in British Columbia. Apply to Director of Nurses.

Instructor in Public Health Nursing, to be responsible for the integration of the community aspects of health throughout the basic course in nursing of a University Degree course. Applicants must be qualified both academically and by experience. Preference given to nurse with degree, other things being equal. Apply, stating qualifications and experience, in care of Box 1, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

Floor Duty Nurse. 6-day week. Salary: $100 per month; full maintenance and free hospitalization. Apply to Supt., Barrie Memorial Hospital, Ormstown, P.Q.

General Duty Nurses. Salary: $100 per month with full maintenance; $105 per month with full maintenance, while on night duty, which comes one month in each 4 months. 6-day week. 3 weeks'vacation with pay annually. Apply to Supt., Lady Minto Hospital, Cochrane, Ont.

Operating-room Supervisor, Pediatric Supervisor, Nursing Arts Instructor. Fully qualified. Full maintenance provided. Apply, stating qualifications, experience, and salary expected, to Lady Supt., General Hospital, Dauphin, Man.

Assistant Supervisor and **General Duty Nurses** for Operating-Room at Victoria Hospital, London, Ontario. Bed capacity, 575. Good salary and Cost of Living Bonus. Post-graduate and practical experience very desirable. Apply, stating school and year of graduation, age, details of experience, references, and date of availability for service, to Supt. of Nurses.

Operating-Room Charge Nurse for 80-bed hospital. Post-graduate experience preferred. Attractive salary; full maintenance; hospitalization; sick leave; holidays with pay. Apply to Supt., Norfolk General Hospital, Simcoe, Ont.

General Duty Nurses for Norfolk General Hospital, Simcoe, Ontario. Salary: $100 per month (including pay for O.R. call) plus maintenance. Increase at end of 6 months, $105, and at end of 1 year, $110. 8-hour day and 6-day week. Holidays with pay; sick leave and hospitalization. Additional $5.00 per month paid for 3:30 shift. Apply to Supt.

Superintendent of Nurses immediately for 125-bed General Hospital (active). All graduate staff. Excellent working conditions, etc. Population, 10,000. Apply to Administrator, Kootenay Lake General Hospital, Nelson, B.C.

Assistant Night Supervisor for 150-bed General Hospital in Southern Alberta. Apply, stating experience and qualifications in first letter, to Supt. of Nurses, General Hospital, Medicine Hat, Alberta.

General Staff Nurse for Night Duty in Saskatchewan hospital. 8-hour day; 48-hour week. Starting salary: $105 plus full maintenance. Apply, stating age, date of graduation, experience, and date available for service, in care of Box 2, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

Special Radio Broadcast

The attention of nurses all over Canada is directed to a special broadcast that is to be featured on the "People Ask" program during the week of January 19. The Viscountess Alexander is to be the speaker and her topic will be "Opportunities for Girls in Nursing." This short address will be broadcast in both English and French. Nurses are urged to consult their local newspapers for the details of time and station, to listen to the broadcast themselves, and to refer all high school girls of their acquaintance to it. The need for adequate recruitment programs for student nurses is as vital today as during the years of the war.

The date: Week of January 19.
The speaker: Viscountess Alexander.
The topic: Opportunities for Girls in Nursing.